

**A PHENOMENOLOGICAL EXPLORATION OF BEREAVED
INDIVIDUALS' EXPERIENCE OF COUNSELLING**

by

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Abstract

This phenomenological study sought to explore the bereaved individuals' experience of therapy. The research question was "How do bereaved individuals experience therapy while going through the grief process?" Four bereaved individuals who experienced the sudden loss of a loved one were recruited from the Lower Mainland. Through in-depth interviews, which were audio-taped, the participants shared their experiences of therapy.

Using Giorgi's (1989) phenomenological analysis, the material yielded four major themes and several sub-themes. Under the first major theme, 'the experience of self' the participants reported a lack of wholeness, hopelessness and depletion. With the second major theme, 'the experience of therapeutic process' the participants reported difficulty engaging in the therapeutic process and inner turmoil. Through interaction with the therapist the impasse created by inner turmoil was resolved, and the following themes emerged: sense of safety, development of trust, formation of positive therapeutic relationship, being inspired by therapist, willingness to engage in the therapeutic process, relief and appreciation of the therapist. Under the third major theme, 'experience of self-discovery and self actualization' the participants reported a growing sense of freedom to be genuine and a willingness to risk being themselves. Under the fourth major theme, 'experience of belonging and fulfilment' the participants reported a sense of purpose, preciousness in life and discovery of one's needs.

In conclusion, the this study indicates the profound change undergone by participants as a result of therapy. The participants were able to acknowledge the pain of their grief and re-discover their own uniqueness. Through the guidance and acceptance of their therapists, these individuals were able move beyond their grief and re-invest in the world.

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DEDICATION

This work is lovingly dedicated in memory of Jean-Paul Vaugeois, my beloved younger brother, whose encouragement and love greatly inspired me on this journey. His untimely death motivated me to search for answers.

and

to all the friends and family members whose constant love, support, and encouragement gave me the confidence that was necessary to complete this work.

CHAPTER ONE

Introduction

In this introductory chapter, the researcher will discuss the following areas; the symptoms of complicated grief; the risk factors that contribute to the formation of complicated grief; the definitions that are salient for this study; the potential problems within the therapeutic process and the purpose of this study.

Symptoms of Complicated Grief

At some point in life, everyone is likely to experience the loss of a loved one. Most will be able to cope with this loss without any major setbacks. In the vast majority of cases, the ongoing emotional support of family members and friends will be sufficient to ease the person's grief. However, approximately 10 to 14 percent of the bereaved population have a great deal of difficulty coming to terms with their loss (Rynearson, 1987; Zisook & DeVale, 1983), and may, for example, become so overwhelmed by their grief as to be unable to function effectively in the world without their loved one.

Those who experience difficulty are at risk of developing what has been variously called "pathological" (Parkes & Weiss, 1983), "unending" (Rynearson, 1987), "morbid" (Sireling, et. al, 1988), "maladaptive" (Mawson, et. al., 1981) or "complicated" (Rando, 1993) grief. The essential difference between normal and complicated grief is in the exaggeration of normal response in the latter. Some withdraw entirely from friends and relatives (Raphael, 1977), others may be unable to express themselves with appropriate openness and feeling in the

presence of peers or intimates. Some may develop a pervasive sense of cynicism, anger or bitterness towards immediate family members and significant others (Rando, 1984; Ramsay, 1979).

Other manifestations of complicated grief include: losing the will to live in a world that is experienced as meaningless; use of drugs or alcohol, or the development of other addictive behaviours as a means of blocking the pain of grief (Parkes & Weiss, 1983); the development of psychosomatic symptoms (Manthorpe, 1987); inability to make a commitment to another relationship because of their fear of another loss (Rando, 1984); or developing compulsive or obsessive behaviours to blot out their feelings. Rando (1984) maintains that these maladaptive behaviours occur when bereaved individuals are unable to process their thoughts and feelings around the loss.

Risk Factors that Contribute to the Formation of Complicated Grief

There are a number of factors that contribute to the formation of complicated grief. Zisook and Devale (1983) noted those who exhibit complicated grief tend to be much younger than the majority of the bereaved population, and tend not to attend funeral rituals. Their initial response to loss is typically more intense and does not dissipate over time. In addition, they are more likely to suffer depression than those individuals who are experiencing grief in an ordinary fashion (Zisook & DeVale, 1983).

Others may experience great difficulty in coming to terms with their grief because of the type of loss. In this regard, those who experienced the

sudden loss of a loved one through accidental death appear to be particularly at risk for developing complicated grief (Manthorpe, 1987; Parkes, 1975; Parkes & Weiss, 1983; Rando, 1984). Without having had an opportunity to prepare themselves psychologically for the death of a loved one, these individuals may "... develop a chronic apprehension that something unpleasant may happen at any time" (Rando, 1984, p. 52).

Another risk factor related to the type of loss concerns whether the bereaved viewed the body of the deceased. Singh and Raphael (1981) note that those who did not see the body had difficulty accepting the reality of death. These authors found that surviving spouses spent a great deal of time fantasizing how their loved one appeared immediately after death.

Other individuals at risk of developing complicated responses are those: (a) who lack information about the normal grieving process (Rando, 1984); (b) have unresolved previous losses (Bowlby, 1980); (c) lack adequate social support (Raphael, 1977); (d) perceive existing support as inadequate (Raphael, 1977; Singh & Raphael, 1981); and (e) had a highly ambivalent relationship with the deceased (Parkes & Weiss, 1983; Singh & Raphael, 1981).

Definitions

There are several terms used in the grief literature which need to be understood clearly. They are as follow:

Loss. This term refers to the physical loss of loved one through death; second is the symbolic loss, which refers to the loss of one's status/role within the family (Rando, 1984; Rando, 1993). For example, when a woman loses her husband, she also loses her role as wife. Another secondary loss may be financial hardship difficulties a widow experiences as a result of the death of her husband. For the purpose of this study, the researcher will be using the term the loss of a loved one through death.

Sorrow. According to the Concise Oxford Dictionary (1976), sorrow is the emotional expression of sadness over the loss of a loved one through death. It is also sorrow over lost opportunities to resolve differences with the deceased. This is especially evident with the sudden loss of a loved one.

Mourning. Rando (1984, 1993) has identified two specific definitions for mourning. First, the individual's expression of grief is dictated by their given culture. For instance, in the past widows wore black as a means of expressing their loss; men wore a black tie and a black ribbon on their coat sleeve. The second definition is based on psychoanalytic theory which focuses on "the conscious and unconscious processes", whereby the bereaved individual gradually lets go to "psychosocial ties binding" them to the deceased, "... with the eventual facilitation of the development of new ties" (Rando, 1993, p. 23).

Process. The Penguin Dictionary of Psychology (1985), defines process as "a series of steps" which marks one's passage from one event or experience to another. For instance, the grieving process begins with the death of a loved

one and the individual's response to the death and ends with the integration of thoughts and feelings around the loss.

Grief. There are many definitions of grief (see, for example, Dersheimer, 1990; Rando, 1984; Worden, 1982). The Concise Oxford Dictionary (1976), defines grief as a "deep or violent sorrow", but the range of reaction to the loss of loved ones is best conceptualized as a continuum from mild to extreme or pathological sorrow (Rando, 1984). As the literature on bereavement suggests, a definition must recognize that grief is a process rather than a state. The normal grieving process has been described in terms of phases or stages. For example, Kubler-Ross (1969) found that dying patients and bereaved individuals undergo five specific stages in their struggle to come to terms with their loss. These stages are denial of death; bargaining with doctors or another individual with greater power (or one's creator); anger at the doctors and later at the deceased for dying; depression over loss; and eventual acceptance over the loss of a loved one. Within these stages or phases, there are distinctive psychological, emotional, spiritual and somatic responses to the loss of a loved one (Dersheimer, 1990; Rando, 1984; Worden, 1982). Finally, grief is an "... emotionally based process, changing its characteristics over time and moving in irregular patterns from greater to lesser intensity" (Dersheimer, 1990, p. 17).

Complicated grief. Complicated grief "... is the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behaviour, or remains interminably in the state of grief without

progression of the mourning process towards completion" (Horowitz, Wilner, Marmar & Krupnick, 1980, p. 1157).

Completed grief reaction. Although the sadness of loss never completely leaves the bereaved in a completed grief reaction, there is a distinctive difference in the quality and intensity of the experience of grief. When people have successfully completed the grief process, the sharp wrenching quality of the pain of grief is gone and the individual is able to think about the deceased without being overwhelmed with emotions (Worden, 1982). Rando (1984) maintains that "successful mourning ... is evident when the bereaved individual is able to remember comfortably both the pleasures and disappointments of the lost relationship" (Rando, 1984, p. 27).

Grief work. For the purpose of this study, the term grief work refers to the process whereby the therapist helps the bereaved individual become aware of the unresolved issues around their loss. The bereaved individual comes to an intellectual and emotional acceptance of their loss.

Potential Problems that may Arise in the Therapeutic Process

Rando (1993) has noted that most bereaved clients have some difficulty engaging in the therapeutic process initially because they are overwhelmed by the pain of their grief. Manthorpe (1987) noted that many bereaved individuals are not responsive to empathy, family therapy or self-help groups, and argues

that they "... fail to grieve normally because of various binds and obstacles and they remain time bound to their loss" (p. 2). Manthorpe (1987) found the use of hypnosis an effective means of helping the bereaved individual move beyond their resistance to therapy and resolve the problematic symptoms of their grief.

Another issues that is critical in the therapeutic process is the timing of the interventions. Rynearson (1987) noted that the crisis intervention model, the most commonly used model of grief counselling, was not suitable for treating complicated or unending grief. One of the major goals of crisis intervention is helping the individual become aware of their repressed thoughts and feelings around the deceased. The basic assumption of the model is that through insight and expression of intense feelings around their loss, the individual will experience resolution of their grief. Unfortunately, this therapeutic intervention appears to reinforce rather than resolve the intense feelings that are associated with complicated grief. In addition, the short term nature of this intervention does not allow for the successful working through of the thoughts and feelings associated with the different phases of the grieving process for individuals experiencing complicated grief.

Various behavioral and cognitive interventions have also been used in treating individuals with complicated grief (Ramsay, 1979; Walls & Meyers, 1985). Although the behavioral interventions have been effective in reducing

dysfunctional behavioral patterns, they are not suitable for all members of this population. Ramsay cautions flooding or prolonged exposure techniques must be used with care, since clients lacking a strong sense of self may be unable to cope with the confrontative nature of these types of interventions.

Rando's (1993) recent publication in this field has shed more light on working with this population. She maintains that clinicians need to be very flexible in guiding their bereaved clients through this painful and time consuming process. In other words, the therapists need to be very resourceful and creative in helping the bereaved individual uncover the unresolved issues around the deceased.

Purpose of the Study

One area that has not been explored is the experiential process within therapy. A phenomenological approach to the study of subjective experience will provide an opportunity to discover how bereaved individuals process their grief within a therapeutic context and may help isolate what experiences in therapy are seen by the bereaved themselves as facilitating a constructive resolution of their grief. The study has taken up this opportunity by offering a phenomenological analysis of the therapeutic experiences of a number of clients who have sought therapy for their grief.

The purpose of this study was to explore bereaved individuals' experiences of therapy. The research question was: **"How do bereaved individuals experience therapy while going through the grief process?"**

The aim of the study was to gain a greater understanding and awareness of the bereaved individual's struggle to come to terms with their loss. Such information will be of great value to clinicians who work with the bereaved population, and will enable us to discover what the clients value about their therapeutic experiences.

CHAPTER TWO

Literature Review

Interest in the study of grief and loss has grown steadily in the decades following the 1917 publication of Freud's **Mourning and melancholia** (for example, Knapp, 1986; Parkes, 1972; Schneider, 1984; 1990). A portion of this growing literature is reviewed here beginning with investigations of the normative processes of grieving and recovery. Attention is then turned to studies of certain more pathological forms of adjustments to loss, the therapeutic process of working with bereaved clients, and finally to a review of intervention studies and of existential-phenomenological therapeutic approaches to mourning. The thrust of this selective review of the literature is to highlight the need for a more detailed understanding of the grieving process within the therapeutic setting.

The Grieving Process

Bowlby (1980) proposed that the grieving process consists of four distinctive phases: numbness, searching, disorganization and despair, and reorganization. There are, according to Bowlby (1980), specific physical and emotional changes within each of these phases. In the initial numbness phase Bowlby describes the individual oscillating between numbness and intense feelings of distress and/or anger. In the second phase, many bereaved

individuals experience "... restlessness, insomnia, preoccupation with thoughts of the [deceased] combined with a sense of the [deceased's] presence" (Bowlby, 1980, p. 86). The typical behaviour in the third phase is an "... endless examination of how and why the loss occurred, and the anger at anyone responsible, not even sparing the dead person" (Bowlby, 1980, p. 93). Through this painful process, the grieving individual gradually recognizes and accepts the loss. Bowlby maintains that the central task in the final phase of reorganization is to "... discard old patterns of thinking, feeling and acting before new ones can be fashioned" (Bowlby, 1980, p. 93). The recovery process is often facilitated by the bereaved individual's inner conversations with the deceased's presence. The bereaved individual may experience this sense of presence for years following the loss.

Cochran and Claspell's (1987) work on the nature of grieving from a phenomenological perspective focused on the internal processes involved in the resolution of grief. Cochran and Claspell (1987) interviewed four men and four women, between the ages of 33 to 50 years old, who had suffered various forms of loss. Because the participants in their study reported becoming acutely aware of their uniqueness and spirituality, Cochran and Claspell believe that the grieving process is a transformative one. Unlike Bowlby (1980), Cochran and

Claspell (1987) focus not on the psychological and behavioral aspects of loss, but rather on exploring the underlying meaning of the grief process.

Cochran and Claspell (1987) also characterize the grieving process as occurring in four distinct phases. The first phase was marked by a progressive depletion of the old ways of being in the world. The most salient pattern being a "... gradual deterioration of energy, spirit, and [sense of] meaning in performance" (Cochran & Claspell, 1988, p. 118). Although painful, this process was vital in clearing the way toward building what Cochran and Claspell term a "new orientation". This phenomenon manifested itself through imagery in "... visions of dying and mutilation" (Cochran & Claspell, 1988, p. 116).

The dominant theme of the second phase is one of struggling to remain functional in a world that is experienced as empty. According to the authors, "... experiences throughout this period are highly imaginative and repetitive" (Cochran & Claspell, 1988, p. 119). The bereaved is unable to make meaningful contact with others and attempts, through imagery, to make sense of their loss. Eventually there is a shift in the grieving individual's imagery toward becoming "... aware of one's own uniqueness ... one's strengths and weaknesses and one's resources and values" (Cochran & Claspell, 1988, p. 120).

In the third phase, the bereaved begins to search for new ways of being in the world and to discover and act upon "... fragments of new meaning in their life, by drawing from the strengths and resources discovered in the previous phases" (Cochran & Claspell, 1988, p. 122).

In the fourth and final phase, this process of reconstruction continues through a discovery of the preciousness of life, of the individuals' own unique spiritual path and in a new and meaningful investment in their own lives.

Kast (1988) offers a Jungian perspective on the process of mourning in a therapeutic context. She maintains that the unconscious material of dreams acts as a guide to the bereaved, allowing them to move through the grief process in their own unique way. In a descriptive analysis of dream series data gathered from 17 bereaved patients, Kast noted five specific thematic patterns: emotional chaos; searching for the loved one; becoming aware of the positive and negative characteristics of the deceased; separation from old patterns of relating with the deceased; and, formation of a new relationship with their loved one. This model differs from Bowlby's (1980), in that Kast (1988) maintains that the searching behaviour is "... an attempt to integrate that which the deceased represented into the newly developing life structure" (p. 59).

In summary, the process of grieving has been characterized as occurring in stages or phases that typically involve a realization of, and struggles with, the

irrational feelings, unconscious dreams, and disturbing images that arise in response to loss. Despite their differing ways of describing the grieving process, however, these researchers seem to agree that throughout this period of chaos and turmoil, the bereaved individual attempts to reorganize and redirect themselves and to redefine their way of being in the world. The common thread in these diverse accounts of the grieving process is an emphasis on letting go of the loved object and the construction of a new vision of the self.

The Recovery Process

Parkes and Weiss (1983) identify three specific tasks that must be negotiated in any successful resolution of the grief process. Parkes and Weiss conducted interviews with 49 widows and 19 widowers, under the age of 46, who had experienced the anticipated, or sudden death of their spouse. Parkes and Weiss (1983) did not include individuals who had lost a loved one through suicide or homicide. Each subject was interviewed on three occasions, with the first interview held three weeks after the loss. In this initial interview, the researchers explored issues leading to the death, the subjects' response to loss, and their social support system. The subjects were given a 30-item checklist in an effort to assess their thoughts and feelings around their loss. A medical history was also taken at this time. During the second interview, held five weeks later, the authors explored the ways in which the bereaved subjects were

coping with the loss. The third, and final, interview was conducted 13 months after the loss. In this interview, the researchers assessed the respondents' process of recovery.

In the analysis of their data, Parkes and Weiss (1983) isolated three distinct tasks facing their bereaved subjects: (i) intellectual acceptance of the loss, (ii) emotional acceptance of the loss, and (iii) formation of a new identity. The first task "intellectual acceptance" was accomplished by "developing an account" of how and why the death of the loved one occurred (p.157). Perhaps not surprisingly, this was particularly difficult for those subjects who had experienced the sudden loss of a loved one. Parkes and Weiss (1983) noted that if this was not accomplished, the individual never relaxed " ... their vigilance against the threat of new loss" (p. 157).

An emotional acceptance of the loss forms the second of Parkes and Weiss's (1983) tasks. The authors maintain that this is a difficult, time-consuming, and painful process. Overcoming this task is said to involve reviewing thoughts and memories around the relationship with the deceased, " ... until the intensity of the distress is diminished to the point where it becomes tolerable and the pleasure of recollection begins to outweigh the pain" (Parkes & Weiss, 1983, p. 157).

The third task comprises the formation of a new identity. Parkes and Weiss (1983) define this new identity as "... a set of assumptions about one's own self, as separate from the assumptions, values, needs, which were held by the deceased or jointly with the deceased" (p. 160). This involves a slow process of movement back and forth, from the original identity to new identity, that is, from being linked with the deceased to being separate from the deceased. Because the bereaved individual may never completely separate him or herself from the deceased, success in this task, or recovery, is a matter of degree. Healthy recovery is realized when the survivor becomes sufficiently separated from the deceased to allow pursuit of the survivor's own needs for autonomy and intimacy.

Worden's (1982) model of the recovery process is based on his clinical experiences of working with bereaved clients. Worden (1982) has outlined four specific tasks in the recovery process. The first is the acceptance of the reality of the loss. The bereaved individual has to come "... full face with the reality that the person is dead, that the person is gone and will not return" (Worden, 1982, p. 11). This difficult task is accomplished by searching for the deceased and discovering that the deceased is indeed gone. In the second task, the bereaved individual needs to experience the pain of their loss by becoming aware of and express their emotional pain.

In the third task, the bereaved needs to "... adjust to an environment in which the deceased is missing" (Worden, 1982, p. 14). This requires gaining an awareness of the secondary losses associated with the death of a loved one. For example, widows need to come "... to terms with living alone, raising children alone, facing an empty house, and managing finances alone" (Worden, 1982, p. 14).

The survivor's last task, is "... the withdrawal of emotional energy and reinvest it in another relationship" (Worden, 1982, p. 15). The bereaved individual gradually begins to invest their energy in other relationships. The bereaved never completely forgets the deceased. If these tasks are not accomplished the bereaved individual is at risk of developing complicated grief and may require therapy to work through the above tasks.

The completion of these tasks, and the movement toward a healthy adjustment to loss, are a painful and often lengthy process. While the duration of the recovery process is known to be highly variable (e.g., Osterweiss, Solomon, & Green, 1984), it has also been reported (Zisook & Shuchter, 1986) that even among otherwise normal individuals, and even years after loss, issues related to unresolved grief are relatively common and can sometimes persist indefinitely. Indeed, as will be discussed in the next section, several authors have argued that resolution of grief can be more than simply incomplete.

These authors have identified what they describe as pathological adjustment to loss.

Pathological Adjustment to Loss

Parkes and Weiss (1983) describe two distinct grief syndromes that indicate pathological adjustment to loss. In the conflicted grief syndrome, the relationship with the deceased is characterized as conflict-laden prior to the death. Parkes and Weiss (1983) interviewed 49 widows and 19 widowers, under the age 46, who had experienced the anticipated or sudden death of their spouse. These authors note that among subjects in this category little distress was shown over their loss in the initial interviews. The authors also note that many of these subjects had experienced the sudden rather than anticipated loss of their loved one. In the follow-up interview, two to four years after the loss, they still suffered from anxiety, feelings of anger towards the deceased, and an intense yearning for the return of their loved one. Parkes and Weiss describe such symptoms as indicating a delayed grief response.

Parkes and Weiss's (1983) identify a second syndrome, the chronic grief syndrome, marked not just by a yearning for the deceased, but by an intense preoccupation with the loved one that results in a near inability to manage one's day-to-day affairs. Feelings of insecurity, lack of confidence, and doubts about

their own mental health were typical of the subjects said to suffer this second form of pathological adjustment.

In contrast to Parkes and Weiss (1983), Rynearson (1987) has identified three distinct grief syndromes: dependent grief syndrome; unexpected loss syndrome; and chronic grief syndrome. The most salient characteristic of the subjects manifesting dependent grief syndrome is that they appear to lack a clear sense of their own self image as unique and separate from the significant other. With the significant other's death comes "... a pathological shift in self-image from that of being strong, caring and worthwhile to discrepant images of being weak, uncaring and incompetent" (Rynearson, 1987, p. 490). The role of self-image in the etiology of this syndrome is supported by Horowitz, Wilner, Marmar and Krupnick (1980) who maintain that: "... a major cause for pathological grief appears to be the reemergence of earlier self-images and role relationship models" (p. 1159). The presence of this poor self-image then, may indicate a failure to adequately differentiate from early attachment figures.

The second syndrome, termed the unexpected loss syndrome, showed an association with post-traumatic stress syndrome. Among subjects who had experienced an unexpected loss, this syndrome was said to characterize those who were unable to process their thoughts and feelings around the loss because this material was too fearful and overwhelming for them.

Rynearson (1987) describes the chronic grief syndrome as applicable to those who have internalized the lost figure rather than expressing their negative thoughts and feelings towards the deceased. Such individuals are said to direct their anger onto themselves rather than the deceased.

Rynearson (1987) maintains that these syndromes interfere with one's ability to resolve issues around the loss successfully and argues that "... [the] development and maintenance of formative imagery and symbols is [sic] of critical importance in supporting the patient and therapist" (p. 497).

The studies reviewed suggest that a number of factors contribute to the development of pathological grief: the bereaved's self-image; the experience of sudden loss of a loved one; and the presence of a dependent or ambivalent relationship with the deceased prior to the loss. Of these factors, the researchers place particular emphasis on the importance of the bereaved's self-image in the etiology of pathological grief.

Therapeutic Process with Bereaved Clients

Rando (1993) and Worden's (1982) models are based on their clinical experiences of working with bereaved clients. Rando (1993) outlined specific guidelines for working with individuals who have developed symptoms of complicated grief. Rando's (1993) model takes into account the specific tasks in the resolution of grief. In the orientation phase, the main task of the therapist is

to provide information on therapy in order to reduce the client's misconceptions about the therapy and gain their commitment to enter the therapeutic process.

In addition to the above, the therapist needs to address the issue of resistance, (as the therapeutic process is a very slow way of uncovering the problematic issues) in order to help the client move into more adaptive ways of coping, and decrease "... the sense of helplessness, lack of control, and fear of being overwhelmed ..." by grief (Rando, 1993, p. 373). This serves two purposes, first it acknowledges the difficulties that might arise. Second, it is a means of working through the resistance in a spirit of cooperation.

In the working phase, the therapist needs to recognize and acknowledge the bereaved's uniqueness. One means of accomplishing the above task is the therapist's unconditional acceptance of the client's disclosure. Another area that needs to be addressed is helping the bereaved cope with the mourning process and their irrational beliefs about the deceased. Along with this, the therapist needs to give clients strategies to deal with the pain of their grief such as taking time out, teaching life skills (nutrition, rest, exercise, so forth) and, informing them of other resources within their community.

Another counselling task is finding methods to empower clients and increase their sense of self-worth. This can be accomplished by giving the client control over "... such issues as timing, content, pacing and

depth ..." of disclosure (Rando, 1993, p. 372). The major reason for giving the client some degree of control is to create an environment where the grieving individual does not become overwhelmed by their affect. The therapist also needs to instill hope of recovery and to help the client have realistic expectations of self.

Rando (1993) emphasizes the importance of helping the bereaved individual come to an acceptance of the death intellectually. This author advocates "... repeated confrontation with the deceased's absence and frustration of the mourner's wishes to be reunited with the loved one eventually teaches the mourner that the loved one is irretrievably gone" (p. 382). Another means of accomplishing an intellectual acceptance of the loss is by talking about the deceased and exploring the circumstances around the death, their relationship with the deceased, unfinished business and so forth. The therapist needs to be aware of hidden issues, lack of affect and the possibility of resistance in order to find appropriate interventions to work through these issues. These interventions would be a means of "grounding" clients and helping them gain "... cognitive control and establish a direction for action" (p. 384).

According to Rando (1993), the bereaved individual needs a great deal of encouragement and permission from the therapist to express their thoughts and feelings around their loss. Time must be taken to help the client identify

and process the emotions around their loss. This can be accomplished by exploring the positive and negative feelings that arise. This part of the process is about gradually coming to an emotional acceptance of their loss.

Rando (1993) also emphasizes the importance of expanding the bereaved individual's social support. One of the means of accomplishing this is by teaching the client assertiveness and social skills. This allows the bereaved individual to make more meaningful contact with their family members and friends. The therapist also needs to elicit support from family members so that they have a greater awareness of the bereaved individual's needs.

Rando (1993) stresses the importance of medical evaluation and treatment when necessary. This is to rule out any possibility of physical illness or the need for medication. Both of these factors may affect the person's level of involvement in the therapeutic process.

Another aspect that needs to be addressed is normalizing and legitimizing the clients' concerns about their mental state. As the client gains information about the grieving process, this increases their ability to tolerate and cope with the emotional pain of their loss.

In Rando's (1984) earlier work with this population, she emphasized the importance of helping the bereaved individual reestablish a sense of meaning in

their life, by reinvesting their energy in other relationships and purposeful activities.

Rando (1993) also points out five specific personal qualities of therapists who work with bereaved clients. First, the need to be present for the clients as they express painful thoughts and feelings around their loss. Second, giving their clients' permission to grieve their loss. The therapist needs to be sensitive and nonjudgmental of their clients' painful disclosures. Third, the clinician needs to have the patience to support the client through this difficult and slow process of recovery. Fourth, the therapist needs to be dependable, consistent, and trustworthy, in order to create a safe and nourishing environment for the bereaved. Fifth, the therapist needs to be willing to make a firm commitment to clients as these individuals may become very dependent on their therapist. Therefore, the therapist must avoid abandonment of the client during this crucial period.

Worden (1982) has outlined nine procedures for working with bereaved clients who have developed symptoms of complicated mourning. The main goal in therapy is "... to resolve the conflicts of separation and to facilitate the completion of the grief tasks" (Worden, 1982, p. 66). Like Rando (1993) Worden emphasizes that the main function of the therapist is to support the bereaved individual through this difficult and painful grief process.

At the initial meeting the therapist has to assess their client's physical health so that any possibility of organic illness can be ruled out. In the second step, the major focus is on establishing a working contact with the client. Worden's (1982) short term intervention consists of 8 to 10 sessions of working with the bereaved individual. The main task at hand is gaining a commitment from the client to explore their relationship with the deceased.

In the third step, the major focus is to "... revive memories of the deceased" (Worden, 1982, p. 66). The therapists encourage their clients to openly discuss the person who has died and what this individual meant to them. The therapist encourages the client to explore the positive memories of the deceased. There are two main reasons for approaching the client in this manner. First, it is a means of establishing a positive therapeutic alliance. Second, after exploring the positive qualities of the deceased, the therapist will eventually explore the painful areas around the death of a loved one, such as the clients' feelings of hurt, anger and disappointment. If at the beginning of therapy, the client is totally preoccupied by the negative affect, the therapist needs to explore this before helping the client explore positive memories of the deceased.

In the fourth step, the therapist needs to assess which of the four tasks have not been resolved. The tasks are: (1) the acceptance of the reality of the loss. If the client denies the reality of their loss, the therapist "... focuses on the

fact that the person is dead and [the client] is going to have to let him go" (Worden, 1982, p. 68). (2) The client has to experience the pain of grief. If the client is unaware of their feelings around their loss, the therapist needs to give the client permission to express "... the positive and negative emotions with regards to the deceased" (Worden, 1982, p. 68). (3) The bereaved individual has to adjust to an environment without the deceased. In the next task, the therapist focuses on helping the bereaved develop new skills, in order to reduce their sense of helplessness in the world without the deceased. (4) The individual has to withdraw emotional energy and reinvest it in another relationship. The therapist helps the client withdraw from the deceased, by giving them permission to stop grieving, "... helping sanction new relationships, and helping the [client] explore the difficulties involved in saying goodbye" (Worden, 1982, p. 69).

In the fifth step, Worden (1982) emphasizes the importance of exploring the bereaved's affect or lack of affect by stimulating the discussion of memories. For instance, if the client has idealistic affect around the deceased, the therapist needs to explore the underlying affect, which maybe anger, guilt or ambivalent feelings towards the deceased. Through this exploration the client can take ownership of the negative emotions towards the deceased which allows the

client to move through their grief. Worden (1982) also emphasizes the importance of finding a balance between positive and negative affect.

The sixth step may not apply to all bereaved individuals. The therapist has to explore and defuse linking objects. This refers to a symbolic object (belonging to the deceased) that the bereaved had formed a strong attachment to. This object is a means of maintaining a link with the loved one. The therapist needs to ask the clients what items they have saved after the death and to assess whether the items hold a special meaning for the clients. If the client has a linking object, the therapist should encourage the client to fully explore the meaning and associations to this object.

In the seventh step, the therapist helps the clients acknowledge the finality of their loss. The therapist needs to assess and explore the client's inability to let go of the deceased.

In the eight step, the therapist needs to explore the client's fantasy of ending the process of grieving. One of the ways of working through this impasse is to ask the client to imagine "... what would it be like to complete the grieving ... What would they lose in giving up their grief?" (Worden, 1982, p. 73).

In the final step, the therapist has to help the client say their final goodbye. Worden emphasizes the importance of allowing the client to

"... to take the lead in this process by asking if the [client] is really ready to say goodbye" (Worden, 1982, p. 73).

As seen, there are specific tasks to be accomplished in the successful resolution of complicated grief. The therapist need to help the bereaved individual come to an intellectual and emotional acceptance of their loss. Once these tasks are accomplished, the therapist needs to help their client find new meaning in their lives and re-establish themselves into the world without the deceased.

Intervention Studies

There is an extensive body of research on the efficacy of various types of bereavement counselling. The focus of this selective review is on some of the existing interventions available to the adult bereaved population, who have experienced normal or complicated grief.

Parkes (1980) reviewed and evaluated the services available for individuals at risk of developing complicated grief. The treatments were individual counselling, group counselling, lay counselling and self-help groups. The population consisted of bereaved widows and widowers who had lost a loved one through illness or sudden death. Clients were randomly assigned to one of the above treatment interventions or to the control group.

The first treatment group received counselling from either (1) a psychiatrist who conducted individual counselling; (2) or a psychiatric social worker who provided ongoing telephone contact; or (3) a therapist who provided supportive group counselling. The primary aim in the first treatment group was to help the grieving individual process their grief. The therapist focused on helping the subject explore the affective states associated with their grieving process and the nature of their relationship with the deceased.

The second treatment group received care from lay palliative care facility volunteers trained by social workers. Clients received ongoing support from the volunteers both before and after the death of their loved one. The intervention consisted of one-to-one support in hospital and in the client's home, where the bereaved had an opportunity to discuss their thoughts and feelings around their approaching loss. The clients were contacted after the death of their loved one and offered additional support.

The third group consisted of persons attending self-help groups in which mental health professionals were sometimes involved. The primary focus of these groups was on mutual support among bereaved participants.

Parkes (1980) reports that although there was an educational component in the first intervention, the amount of direct individual contact as opposed to telephone consultation by psychiatrist was the key factor in helping clients move

beyond the acute phase of their grief. Significant changes were observed within this group in terms of attitudes towards the deceased and willingness to accept support from family members. There were no reliable changes in health status as assessed immediately after treatment intervention. In the follow-up evaluation, however, subjects who received direct individual contact showed significant improvement in their overall health status.

There were less dramatic changes in health status among those who received supportive group counselling by a therapist. Parkes (1980) does not identify the specific health or psychological changes that occurred in this group. However, Parkes notes that clients with reactions of guilt or self-blame benefited most from this treatment intervention.

The changes in the health status and psychological states were not significant in interventions conducted by lay volunteers or in self-help groups. However, in the three-year follow-up evaluation, there was less deterioration in the health and psychological states in subjects who had received ongoing support from lay volunteers than those who had participated in self-help groups.

In summary, Parkes (1980) has shed some light on the efficacy of these different interventions. Clients receiving professional intervention appear most likely to benefit, at least in terms of overall health status. What is needed,

however, is more in-depth analysis of the psychological as well as physical health benefits of various intervention techniques.

Constantino (1988) was interested in comparing the effectiveness of two intervention strategies for the general bereaved population. She conducted an 18-month study of 117 bereaved widows who had experienced either sudden or anticipated loss of a loved one. Subjects were randomly assigned to one of three groups. Group 1 received a six-week Bereavement Crisis Intervention. Group 2 received a six-week Social Adjustment Intervention. The remaining subjects were placed in a control group. The leader of the crisis intervention group played an active role, by "... being an active listener, theme planner and mental health educator, leading discussions and providing insights to each member's plight" (Constantino, 1988, p. 84). In the social adjustment group, the leader played a more passive role, providing social outings, rather than specific opportunities to explore grief.

Subjects in all three groups completed the Beck Depression Inventory, the Depression Adjective Checklist Form E, and the Revised Social Adjustment Scale during the initial meeting, and again after the intervention, as well as at 3-, 9- and 12-month post treatment. Upon completion of treatment, the crisis intervention group showed a significant decrease in depression symptoms and an increase in social adjustment. Follow-up evaluations, however, revealed that

these changes did not endure. Constantino (1988) concluded that the intervention in Group 1 was too brief to establish long-term positive changes in the subjects' lives.

In the social adjustment group (Group 2) a gradual increase in depression and a corresponding decrease in levels of social interaction was observed upon the termination of the program and in follow-up evaluations. This suggests that more therapeutic interventions are needed within the social adjustment program in order to provide opportunities to share grief more openly and to allow more meaningful contact between members of the group.

No reliable changes were observed within the control group over the course of the study. The level of depression and social interaction of these subjects fell in the mid-range at the outset and remained within this range throughout the study.

In summary, Constantino (1988) has been able to identify specific changes in the mood state and social interaction in the treatment groups. The more directive intervention was associated with beneficial changes at the end of treatment, but unfortunately these changes were not enduring. The inclusion of a control (no treatment) group revealed that time does not heal all wounds, as both treatment groups, but not the control group, showed more positive changes over the course of the study. Although some beneficial effects were evident in

the crisis intervention treatment group, Constantino (1988) recommends replication to see whether variables such as age, length of widowhood, cause of death, amount of responsibilities, religion, or race play important roles in the resolution of grief. To date, replication including all these variables has not been undertaken. Finally, as this researcher has only included widows in her sample, there is a need to look at parents and other individuals who have experienced sudden loss.

A more structured group intervention study was conducted by Moran (1988). The purpose of this study was to develop and evaluate a preventative treatment program for the bereaved population. Thirty bereaved individuals, who had experienced either the sudden or anticipated loss of loved one, entered an eight week program involving educational and experiential components as well as ongoing homework assignments. The educational component focused on discussion of the physical, psychological and spiritual aspects of the grief process. In the experiential part of the program, the participants were encouraged to explore both the positive and the painful memories around their loss. They were also encouraged to explore the role change, and the loneliness that accompanied this major transition. The final component of the program consisted of weekly written assignments related to topics discussed during the program and regular entries made in a journal.

Participants completed the Beck Depression Inventory (BDI) and Hopelessness Scales (HS) on a weekly basis and at a three-month follow-up. Moran (1988) noted that all the participants' levels of depression and hopelessness decreased over time. In addition to administering the BDI and the HS, Moran (1988) conducted a clinical interview with each participant following the treatment intervention. These interviews shed some important light on individual differences in response to treatment and level of recovery. For instance, many subjects reported feelings of loneliness, anxiety, sadness and difficulties in making decisions, and a small percentage of participants viewed the future as scary, frightening and bleak. A possible conclusion from these reports, would indicate that for these subjects, therapy was incomplete.

While these findings are revealing in terms of individual differences, Moran (1988) did not isolate other variables such as the circumstances surrounding the death or the participants' relationship to the loved one. For example, did those who experienced sudden loss view the future more negatively than those who had experienced anticipated death? Did parents who lost a child view the future differently from those who lost a spouse? Still, Moran (1988) has given more insights on the recovery process, as she has been able to identify some of the distinctive changes in mood state within the bereaved population. Moran's (1988) study also examined a more representative

sample of bereaved persons by including parents who had experienced sudden loss, as well as an exploration of the subjective experiences of the subjects.

There are, however, a number of shortcomings in this investigation. First, the study was time limited, so we do not know the lasting effects of this intervention strategy. Second, Moran (1988) did not isolate the differences in the subjective experiences of those who had experienced the anticipated, as opposed to the sudden death of a loved one. Finally, a control group was not used, and thus, we can only speculate that the observed changes can be attributed to the treatment intervention.

In recent years, clinicians have begun to use imagery as a means of helping individuals with unresolved grief symptoms. Melges and DeMaso (1980) designed a therapeutic intervention consisting of three specific steps: (1) cognitive structuring for the decision to grieve and clarification of the procedure, (2) guided imagery for reliving, reusing and revisiting scenes of the loss, and (3) future-oriented identity reconstruction.

Although objective measures were not used in assessing psychological changes among their clients, Melges and DeMaso (1980) report that their brief therapy yielded promising results after 6-to-10 sessions for 100 bereaved individuals experiencing difficulties in coping with their pain of loss (Melges, 1972, cited in Melges & DeMaso, 1980). Melges and DeMaso (1980) argue

that present-time guided imagery is an effective means of accessing the core issues that bereaved individuals must resolve. They recommended more research into finding alternative interventions for treating unresolved grief.

Mawson, Marks, Ramm and Stern (1981) conducted an behavioral intervention study of 12 patients with morbid grief. Subjects were randomly assigned to either the guided mourning group, or to a control treatment group. The treatment consisted of six 90 minute sessions over two weeks. The major focus of the guided mourning group was on the exploration of "... painful memories, ideas or situations, both in imagination and real life, related to the loss of the deceased" (Mawson et al., 1981, p. 185). In contrast, the control treatment group was encouraged to avoid thinking about the deceased and were also encouraged to use techniques such as "thought stopping" and relaxation exercises between sessions, as a means of dealing with intrusive thoughts about the deceased.

The subjects were given the Bereavement Avoidance Test, Physical Symptoms of Grief, Wakefield Depression Inventory and Fear Questionnaire at the beginning of study, and at 2, 4, 8, 12 and 28 weeks. Although only the guided mourning group showed significant improvement in all of these areas, immediately after the end of the treatment intervention and in the follow-up evaluation, there are a number of methodological problems in this study. First,

the duration of the treatment was only 2 weeks. Second, the sample size was very small. Despite these shortcomings, the authors conclude that: "... the results suggest that guided mourning is a useful ingredient in the management of morbid grief, although the effects [were] not as potent as might have been hoped" (Mason et al., 1981, p. 191).

In an effort to increase the potency of this intervention, a replication was undertaken by Sireling, Cohen, and Marks (1988). In addition to increasing the sample size to 30 subjects, these researchers modified the Mason et al. (1981) design by lengthening the treatment intervention from 6 sessions over a 2-week period to 10 sessions over a 14-week period. Subjects were randomly assigned to either the guided mourning group or to an anti-exposure group. Sireling et al., (1988) also altered the treatment by providing "... more systematic advice, support and help concerning relationships, work and leisure activities " (p. 122), to both of the treatment and control subjects.

Sireling et al. (1988) did a more in-depth evaluation of these two interventions strategies. Participants completed the Wakefield Depression Inventory, Physical Symptoms, Fear Questionnaire, Anxiety and Social Adjustments, Attitudes towards Self and the Deceased, Hostility-anger-guilt Questionnaire, and the Grief Activity and Avoidance Questionnaire during the initial meeting, and at 2, 14, 28, 54 weeks. The Bereavement Avoidance test

was administered during the initial meeting, and at 18, 28, and 54 weeks. The Beck Depression Inventory was given in the 2nd, 18th, 28th, and 54th week.

Although there were no significant differences between the two treatment groups immediately following the intervention, a reliable improvement within the guided mourning group was observed at the nine month follow-up on ten separate outcome measures. The anti-exposure group improved on only four outcome measures, (i.e. Texas Inventory of Grief, Wakefield Depression, Global severity, and Work), at this follow-up assessment.

In summary, the behavioral interventions just reviewed have presented a clinical sample of individuals suffering from symptoms of maladaptive grief. They have also used objective measures to assess the distinctive changes in their sample.

The replication of the Mawson et al. (1981) study, allowed Sireling et al. (1988) to extend their treatment intervention and include a control group. They also included objective measures, to monitor specific changes within their sample. Unfortunately, however, by excluding individuals experiencing acute grief, Sireling et al., did not have a representative sample of the bereaved population. It is the writer's belief that these interventions would be too stressful for the recently bereaved because of the intensity of this treatment program.

All intervention studies cited in this review have used quantitative research methods. The investigators have focused on identifying reliable and objective measures of adjustment, such as health status, emotional and behavioral states, in order to test their research hypotheses. Rennie (1988) has been critical of this method because it ignores the client's experiences of therapy. It is true that very little importance has been placed on investigating the client's experiences in traditional research in this area. Clinicians may interpret the client's feedback, "... as evidence of defensiveness, fantasy or transference" (McLeod, 1990, p.2), while behaviour therapists usually focus on the client's behaviour and how this could be changed or modified. In both case, little importance is placed on internal subjective events. The phenomenological approach appears to be a viable and valuable alternative method with which to examine the individual's experiences of therapy and to identify the most salient themes within this phenomenon. What this method offers is a means with which to chart subjective experiences of the bereaved during psychotherapy.

Existential Phenomenology

Brice (1991) conducted a phenomenological investigation of bereaved mothers' experiences of sudden loss of a child. He interviewed three participants over a period of 12 months. Through an in-depth analysis of the transcribed material from these interviews, the author concluded that maternal

mourning was fundamentally a relational phenomenon. Brice (1991) identified three salient patterns within this complex phenomenon: (1) "... it is always a relationship that is mourned and in order to mourn, a bereaved mother must mourn another person", (2) "... it is a paradoxical phenomenon" (p. 16), and (3) there are 15 existential themes that form a structural whole.

Brice noted that his participants did not go through their grief in an orderly manner, rather, "... maternal mourning [encompassed] a series of themes which weave themselves throughout the mother's experience, in greater and lesser intensity, in a nonlinear or phasic fashion, probably for the duration of her life" (Brice, 1991, p. 16). This author also noted that these individuals never completely accepted the finality of their loss. Each experienced their dead child as "... both a part of and apart from her, that she uses her child's 'voice' as a 'transitional object' ... that comforts her and guides her through her mourning" (Brice, 1991, p. 17). Brice believed that the most painful task for the bereaved mother was the loss of the "... lived dialogue with her child" (Brice, 1991, p. 17).

The most salient aspect of this investigation was Brice's ability to capture the depth of the bereaved mothers' experience of mourning. Secondly, he was able to detail their struggles to deal with their loss, which were plagued with ambiguity.

Reeves's (1989) phenomenological study of bereaved individuals' experiences of rituals has cast more light on the nature of the resolution of maladaptive grief. This author interviewed five bereaved individuals, before and after they had developed and enacted their own unique ritual. These individuals had suffered various forms of losses, for example, loss of mother, loss of creativity, loss of meaningful relationship between mother and daughter, physical loss from an accident and inability to come to terms with early loss of mother. The participants in this study either designed rituals on their own or in conjunction with psychotherapy.

In the analysis of the transcribed material from the interviews, Reeves (1989) was able to isolate the following themes: "... anxiety; meaning; choice; acceptance of reality; healing and growth" (p. 147). Reeves describes the motivating factors that enhanced the development of these rituals was the individual's search for new meaning in a world which they perceived as meaninglessness and a growing awareness of unresolved issues around their loss. Reeves also notes that each participant selected their own unique symbols to represent their old and new state of being within the rituals. Through the enactment of the rituals, the participant gained an awareness of their personal power to effect change and accept responsibility for their lives. According to Reeves, the involvement of significant people in the preparation and enactment

of a given ritual also enhanced the healing process, allowing the individual to face and accept the reality of their loss in a supportive and meaningful environment.

Reeves's (1989) work suggests that personal rituals may be a viable alternative intervention for individuals with unresolved grief. The phenomenological method allowed Reeves to move beyond behavioral descriptions and symptom relief to discover the participant's own unique way of healing.

Phenomenological Studies in Psychotherapy

Rennie and his colleagues (Angus & Rennie, 1988; Rennie, 1989, 1990) developed an alternative method of investigating the clients' subjective experience of therapy. In Angus and Rennie's (1989) exploratory investigation, separate interviews were conducted with clients and their therapists, within 24 hours after a therapeutic session. Four therapeutic dyads participated in this investigation. The participants were from a general clinical population and had been in therapy for at least 12 weeks. Two participating therapists followed an eclectic approach, one was described as having a psychoanalytic, and one a gestalt approach.

Two techniques were employed to help the participants recall their experiences of therapy. First, audio tapes of the sessions were made available,

and second, participants were "... asked to recall thoughts, images, emotions and feelings they were experiencing at that moment in therapy represented in the tape segment just played" (Angus & Rennie, 1989, p. 373). This latter technique is referred by Angus and Rennie as the Interpersonal Process Recall (IPR) technique.

Angus and Rennie (1989) used a phenomenological and grounded theory approach to analyze their data. They were able to identify two global categories in their analysis: (1) 'metaphoric communication interaction' which refers to the metaphors that emerged within the therapeutic dyad, and (2) 'associate meaning context' which refers to the metaphors that represent the inner experiences of the participants. These associate metaphors were thought to symbolize the participants' inner experiences in three ways: "... they provided an associative link to the experience; they represented aspects of self-identity; and they symbolized the role of relationship patterns" (Angus & Rennie, 1989, p. 374).

These interventions, according to Angus and Rennie allowed the participants to gain a greater self awareness and deepen their experiences of therapy, and to acquire a "... fuller awareness of [their] implicit beliefs and emotions" (Angus & Rennie, 1989, p. 377). Perhaps the greatest value for the participants was the potential opportunity to integrate "... a rich mixture of childhood recollections, fantasies and feelings" (Angus & Rennie, 1989, p. 377).

Lastly, these authors noted that the metaphors that emerged within the therapeutic dyad either enhanced or detracted from the level of awareness for the clients.

Rennie (1990) points out that the major problem with the I.P.R. technique as employed in earlier studies focused on particular events in therapy, rather than on an examination the whole session. Rennie notes that this focus "... may fail to capture some of the more subtle, covert aspects of the experience of therapy" (Rennie, 1990, p. 155). In his replication study, Rennie (1990) changed the format by having each participant listen to the entire audio tape of his/her session. The participants were directed to stop the tape whenever they recalled something meaningful. Through the use of this 'self-reflective process', the participants were able to gain a greater understanding of their therapeutic experience.

There were 12 participants in this study. These individuals were currently in therapy. The therapeutic orientation of the therapists were: client-centered, gestalt therapy, transactional analysis, behaviour therapy, and eclectic therapy.

The grounded theory approach was used to analyze the data gathered in the interviews, which isolated four major categories of experience: (1) the client's relationship to personal meaning; (2) the client's perception of his/her

relationship with the therapist; (3) the client's experience of therapist intervention; and (4) the client's awareness of outcome.

Although the above studies have provided insight on the participants' subjective experiences of therapy, Rennie (1990) admits that there are potential problems with the validity of the participants' accounts. The major problem at hand was the individual differences in processing information. For instance, some clients were able to be more self-reflective in the therapeutic hour, so they would be able to recall their experiences more clearly. Other clients were more emotionally involved in the therapeutic hour. These individual may have used the interview to figure out what had actually occurred in the session.

Another potential problem was how the interviewer may have influenced the participant's disclosure, specially when the participant was having difficulty articulating his/her experience. Rennie (1990) believed that through the process of 'co-construction' of the therapeutic events, the participant would gain a greater awareness of his/her own unique experiences of therapy. The term 'co-construction' refers to the process whereby the researcher and participant actively engage in exploratory dialogue, in order to discover the underlying meaning of the participant experiences of therapy.

In summary, Rennie has been able to shed more light on the subjective experiences of clients. Through the interview process the participants were able

to gain a greater awareness about themselves and how the therapist influenced their responses. There are a number of shortcomings to this study. First, this author did not identify the presenting problems of the clients. We do not know if any of these clients were dealing with loss. Second, this researcher does not give us the end results of therapy because he only examined one therapeutic encounter. Third, the researcher and participants were totally dependent on external clues, that is, the extensive use of tape recorded sessions to gather their data.

In conclusion, the phenomenological approach appears to be a worthwhile method of investigating the bereaved individual's experience. Using this approach, both Reeves (1989), and Cochan and Claspell (1987) have highlighted the importance of the struggle to make sense of one's loss and the transformational processes that accompany the exploration of grief. Brice (1990) provides an example of the utility of a phenomenological approach in the study of mothers who have experienced the loss of a child.

Rennie (Rennie et al., 1988, 1989, 1990), using a sample from the general clinical population, has demonstrated how clients can gain greater self-awareness through examining and reflecting upon transcribed material from the therapeutic sessions.

Although these authors and others have generated valuable insights concerning the processing of grief, there still is lack of specific information regarding the bereaved's experience of therapy. It is my hope through this research to investigate this area in more depth. The basic, and as yet unanswered question to be explored in this work is: "How do bereaved individuals experience therapy while going through the grief process?"

CHAPTER THREE

Methodology

The purpose of this study was to record and analyze the bereaved person's experiences of therapy. This required three specific steps: first, the screening and selection of participants; second, the interview procedures that facilitated the discussion of their experiences; and third, the interpretation of the interviews from a phenomenological perspective. These separate steps are discussed in the sections to follow, beginning with a brief description of the phenomenological approach.

The phenomenological approach provides a descriptive account of the individual's experience "as lived" (Giorgi, 1985). This method was particularly appropriate for investigating the experiences of bereaved clients who have undergone therapy, (as there is very little research in this area). The goal of this research then was to detail the ways in which bereaved persons struggle to make sense of a world without the deceased loved one and the role of the therapeutic intervention in facilitating the resolution of this struggle.

As with quantitative methods, there are specific guidelines to follow when using a phenomenological approach. Osborne (1990) has identified three important components in conducting this type of investigation: (1) to reflect

upon and explicitly identify researcher's assumptions (p. 81); (2) the establishment of good rapport between researcher and participant to elicit the most salient experiences of the participants (p. 82); and (3) the validation of researcher findings and interpretations, through continual consultation with the participants, as to the accuracy of their interpretations (p. 87).

In the pages that follow I will explain in more detail how these guidelines were incorporated into the design and execution of this research project.

Design and Procedure

Criteria for Participants Selection

In selecting participants, Cochran and Claspell (1987) emphasized three important criteria: (1) the individual has experienced the phenomenon under investigation; (2) they are able to articulate their experience; and (3) they have the ability to talk about their experience, without being overwhelmed by or too distant from the contents of their experience.

In selecting participants, the following criteria were used:

1. The bereaved individual was under the age of 60. It is the author's belief that a more elderly population would not be suitable because of the frequency of multiple loss experiences in this population (e.g., loss of spouse, children and significant friends).

2. The bereaved individual will have sought therapy for issues related to grief and loss of a loved one through death. The major reason for this criteria is to ensure that the individual has had an opportunity to work through the unresolved issues around their loss. Therefore, they would have a greater awareness of their recovery process.
3. The bereaved individual will have undergone therapy in the preceding 6 to 18 months and have been referred to participate in this study by their therapist. The major reason for this criteria was that these individuals would have had the opportunity to process their grief. Consequently, the participants would not be overwhelmed by the material generated through the interview process. Another factor is that those individuals who have been out of therapy for more than 18 months may have difficulty recalling their therapeutic experiences.

Recruitment

A total of 30 local therapists and colleagues in the field of counselling and psychotherapy in the Lower Mainland of British Columbia were contacted by letter. The first 10 therapists contacted were known personally by the researcher. It was suspected that personal contacts would be most effective. This was proven to be the case when the researcher tried to contact an additional set of 20 therapists, who had been referred to her by colleagues.

All the therapists were sent a letter of intent, which outlined information concerning the nature of the study. They were asked if they had any former clients who were suitable for this investigation (see Appendix A). If the therapists had any former clients who had resolved their loss through counselling, these clients were asked to contact the researcher if they were interested in participating in the study. If the former clients agreed, the therapist gave them the researcher's name and phone number.

The final selection of individuals was due to the difficulties in accessing this particular population, because not all therapist work with the bereaved individuals. Second, many of the therapists contacted had bereaved clients who were currently in therapy, therefore they did not meet the criteria for this study. Third, some individuals had completed their therapy but were currently in an ongoing support group.

A telephone screening interview was then conducted with former clients who expressed interest in participating in the study. In this interview, a brief description of the nature of the present study was given (i.e., length of interview, tape recording sessions, time commitment and confidentiality) and the suitability of the participants, according to the criteria for selection, was assessed. Nine individuals were referred to the researcher by their therapists. Four of these individuals did not meet the criteria for this study. Two had not

completed their grief work with their therapists. One had suffered the loss of her child because she had given up her child for adoption and was currently in therapy. Another had entered therapy for drug and alcohol problems and later uncovered unresolved grief issues around the death of her brother. Of the five remaining individuals, one was scheduled for an interview and later declined to participate in the study because she could not recall her therapeutic experiences. The remaining four individuals, who met the criteria, were scheduled for interviews. Three of the participants were interviewed at the researcher's residence. The fourth participant was interviewed in her home.

The interview. During the first interview, the procedures involved in the study were reviewed, and participant's questions or concerns regarding the investigation were addressed. Following this, the participants were asked to read and sign two consent forms (Appendix B). This initial portion of the interview was also be used to establish a rapport with the participants.

All interviews were audio-taped. Using an open-ended question format, the researcher encouraged the participants to reveal their stories of their experiences of therapy. The interview was started with the following statement: We know very little about the bereaved's experience of coming to terms with loss of a loved one through counselling. The existing literature in this area has focused on the specific behavioral changes associated with the grieving process.

Very little attention has been placed on investigating the client's experience.

Could you tell in as much detail as possible, how you attempted to make sense of your loss, through your experience of counselling? It may be helpful to think of your experience and describe it to me as a story, with a beginning, middle and end.

The second part of the interview consisted of questions that allowed the participant to share the most salient information of their own unique experience of therapy, without too much prompting from the researcher (see Appendix C). The researcher used counselling skills, such as empathy, paraphrasing, reflection and clarifying questions to help the participant describe their experience more fully. This also allowed the researcher and participant to form a more meaningful relationship.

The first interviews varied between 1-1/2 to 3 hours in length. At the end of the interview, the participants were debriefed and encouraged to write any relevant information or impressions that might arise following the interview and bring this information to the second interview. According to Osborne (1990) this is an excellent means of engaging the participant for the second interview (p. 84).

During the second interview, the participants were be given a narrative summary of their therapeutic experiences, which included the researcher's

synopsis of the participants' description of the beginning, middle and end of the therapeutic process. The participants were asked to verify the accuracy of the summary and encouraged to add additional information. The summary was then discussed in greater depth and any relevant information was added.

The second interviews varied between 1-1/2 to 3 hours in length. At the conclusion of this interview, the researcher debriefed the participants because of the sensitive nature in the material generated during this session. The participants expressed a deep appreciation for this opportunity to further discuss their experience of therapy. They were also pleased to discover the changes they had made during this time.

Analysis of Data

All interviews were transcribed and summarized by the researcher. This was followed by an in-depth phenomenological analysis as outlined by Giorgi (1985; 1989). This analysis was carried out in four stages. First, the researcher read the entire transcribed interviews several times in order to gain a total sense of the psychological perspective of the participants' experiences of therapy. Second, transition points (meaning units) within the transcribed material were identified. Third, each meaning unit was paraphrased in order to identify the most salient theme. Fourth, most human processes have a beginning, middle and end. The researcher assumed that the responses to these different phases

may differ from each other. Therefore, the researcher decided to include in the narrative summary an encapsulation of the participants' description of the beginning, middle and the end of the therapeutic process. Fifth, after the participants validated their experiences, the researcher isolated those experiences which occurred in all four participants' description of the therapeutic process. Upon reflection, five major themes were identified. These major themes contained several sub-themes, which represented the participant's experiences of therapy.

Ethical Considerations

Steps were taken to ensure the anonymity of participants. The voluntary nature of their consent was explained to each participant. In order to ensure participants and therapists confidentiality, names were randomly selected. The participants were given the following pseudonyms; Chantelle, Lewis, Sophie, Amanda. The therapists were given the following pseudonyms; Connie, James, Beth. Participants were also informed that the audio-taped and written transcriptions of the interviews would be destroyed at the conclusion of the study. (These instructions are described in more detail in the consent form included as Appendix B).

Assumptions

There are several assumptions in conducting this type of investigation. First and foremost, the researcher assumed that the therapeutic relationship can play a vital role in helping individual's understand the grieving process and dealing with bereavement issues. Second, an orderly sequence of stages was not anticipated to emerge from the analysis of the data (Brice, 1990). Third, individuals can be conscious of the important dimensions of therapy as experienced. Fourth, therapy can be an adjunct to the process of resolving grief psychologically. Fifth, from my clinical experience with the bereaved population, spontaneous imagery may play a significant role in helping clients gain a sense of separateness from the deceased.

CHAPTER FOUR

Results

In this chapter I will describe the bereaved individuals' therapeutic experiences; the orientation and structure of the therapeutic experience; the participant's history; a listing of the major themes and sub-themes found in the phenomenological analysis of the transcribed material taken from the interviews of the participants, which reflect their experiences of therapy; and a full description of each of the themes.

The Orientation and Structure of the Therapeutic Experience

Three therapists in this study were eclectic in their therapeutic orientation which included use of imagery, art therapy, photo-therapy, and journals. One therapist used the client-centered approach, with the re-authoring therapy. The above information was gathered from conversations with three of the participants' therapists. The fourth participant informed the researcher of the various techniques that her therapist employed. The participants' length of treatment and frequency of sessions varied among the participants. Lewis saw his therapist on a bi-monthly basis, for the period of one year (about 24 sessions). Sophie saw her therapist on a monthly basis for two and a half years (about 30 sessions). Chantelle saw her therapist on a bi-monthly basis for a

year and a half (about 20 sessions). Amanda saw her therapist on a bi-monthly basis for a year and a half (about 24 sessions).

Participants' Histories

All the bereaved individuals who were interviewed for this study were recruited through letters sent to local clinicians in the Lower Mainland. The participants and their therapists were given pseudonyms for this study. The following is a brief history of each participant:

Chantelle. Chantelle, aged 23, was the youngest of three children. In her teens, she experienced a great many upheavals. Within a short period of time, a friend's mother committed suicide, her father became very ill, several people whom she knew were seriously injured or died in traffic accidents. Being overwhelmed by these events, Chantelle searched for help and ended up seeing several psychiatrists. In Chantelle's opinion, the psychiatrists were of little or no help to her because they recommended medication rather than taking the time to listen to her.

A few years later, her mother was diagnosed with leukaemia and underwent extensive treatment which involved a bone marrow transplant. Afterwards, Chantelle spent several months nursing her mother back to health and felt very hopeful of her recovery.

Chantelle was stunned when her mother died. "After the shock of my mother's death had worn off," Chantelle was haunted by images of her mother dying and the burial which followed. At that time she realized that she needed some help to work through her grief. So, she searched for an appropriate therapist, someone who would be willing to listen to her. Chantelle's therapist used an eclectic approach.

Lewis. Lewis, aged 40, was the eldest child in a family of five. He had a "very traumatic childhood" because of his mother's untimely death when he was eight years old. This loss was devastating for him and he was further traumatized by his father's refusal to allow him to speak about his loss or the feelings which he had in response to the death of his mother. According to Lewis, he learned to deny his feelings, and he focused on developing his intellectual abilities.

He left his family home in his early teens, and when he was of age, he entered the police force where he stayed for many years. He married and had one child. In his late twenties he decided to enter university. After completing his B.A. and M.A., he started teaching at a local college.

In 1990, he experienced a number of significant losses, that is, sudden death of a dear colleague, accidental death of a younger brother, accidental death of his mother-in-law and a few months later the death of his aunt. These

deaths of people close to him made him feel very uneasy. He also became acutely aware of his own mortality. However, he decided to bury himself in his work, because this gave him a feeling of normality. Unfortunately, as time went by, he was very tormented with the feeling of being a failure. He found that he could not cope with the demands of his teaching position and his family responsibilities. So he decided to take a leave of absence from the college and turned to his family doctor for help.

Lewis considered this phase as a very frustrating experience because his doctor placed him on anti-depressants, which only served to increase his sense of worthlessness. Six months later, he decided to search for a therapist who would help him deal with the recent losses. Lewis wanted a human being with "compassionate understanding". Lewis' therapist's used a client-centered approach.

Sophie. Sophie, aged 53, was one of four children. Following her graduation from nursing school, she worked as a nurse in a hospital setting. She saw her identity as a "caregiver". Later, she married and had a son and a daughter. She was very dedicated to her family and had a very close relationship with her children and husband. She lived for her family.

Four years ago, during a family excursion, Sophie's daughter was killed in an accident. The person responsible for this tragedy was Sophie's brother-in-

law, who was unable to comprehend the family's sorrow. He was totally preoccupied by his own needs and very fearful of being sued and became quite removed from the tragedy. Sophie was bewildered by his actions and lack of emotional support towards the family.

Sophie became totally overwhelmed by her grief and did not know where to turn for help. She was not able to care of herself or her family. Sophie's 19-year-old son made all the necessary arrangements during and immediately after her daughter's accident because either Sophie nor her husband were able to cope. In fact her son did all of the coping while Sophie withdrew from family, friends and society as a whole. The only place where she felt "totally accepted" was when she was with her pet. Sophie felt her cats were always there for her. Sophie imagined that her cats intuitively knew what she was feeling, or thinking and always were there for her, no matter what mood she was in. She felt that she could depend on them.

Some time later, she sought help from her doctor, who prescribed medication because she kept reliving the accident scene. Along with the medication, Sophie used alcohol to cope with her unbearable pain.

Gradually, Sophie started to look for alternatives within her community, only to find that there were very few resources available for bereaved parents. She became very discouraged by this discovery, but found a therapist who

helped her through this difficult and painful process. Sophie's therapist employed an eclectic approach.

Amanda. Amanda, aged 57, was an only child. She grew up in England and went to secretarial school, because "[she] was too young to go out and to attend university." This was a great source of disappointment for her as she would have liked to go into a social work program. While working, she met John and later married. They moved to Vancouver. Over the years, they had three daughters and moved around the country a great deal. As time went by, their relationship became very stormy and they separated for a period of time because they could no longer communicate with each other. At that time Amanda sought counselling, in the hope that they would be able to sort out their differences. Unfortunately, her husband was not very receptive to counselling.

The emotional trauma of this separation was so overwhelming to Amanda that she contacted her doctor, who placed her on anti-depressants. Eventually, she decided she no longer needed medication and became reunited with her husband.

Four years ago, while playing badminton with her husband, he suddenly developed severe chest pain. He was admitted to the local hospital, where he died of a heart attack shortly after being admitted. Amanda had a great deal of

difficulty comprehending this tragedy. Her husband had received regular medical check-ups, and she thought he was in reasonable health.

After the memorial service, Amanda found herself very restless and haunted by her relationship with her husband. She also had a great deal of sadness over lost opportunities to work out her differences with him. She contacted her family doctor who attempted to explain to her what had happened to her husband. Eventually, he referred her to a psychiatrist because he could no longer help her. According to Amanda, her experience with the psychiatrist was rather negative because he could only offer her medication. He did not appear to be interested in talking about the issues that were troubling her. As time went by, Amanda realized that she needed more than the psychiatrist could offer her. She also realized that medication was not the answer to her pain, as this would interfere with her grieving process.

Amanda attended grief and loss classes where she met other widows. This was a great source of inspiration for her because other widows had indeed survived their loss. She also made a positive connection with the therapist, who led these classes. A few months later, she started seeing this therapist as a client. Amanda's therapist used an eclectic approach.

Overview of Themes

After the initial interviews, the researcher transcribed the material presented by the participants. A phenomenological analysis of the participants' experiences of therapy was then undertaken. Finally, the narrative summaries of the beginning, middle and end of therapy were presented to the participants during the second interview to validate the accuracy of the researcher's interpretation of their therapeutic experiences.

The themes and sub-themes gleaned from the participants' descriptions of the beginning, middle and end of therapy will be discussed using quotations that most accurately reflect the participants' experiences.

Before discussing the major themes and sub-themes, the researcher will provide an outline, with a short definition or explanation of the major themes. These major themes and sub-themes are presented in the order they occurred in the interview process. These themes include the following experiences:

The experience of self. This major theme refers to how the participants felt about themselves, the extent to which they could identify and accept their perceptions, values, feeling and beliefs. As can be seen from the following sub-themes, a negative sense of self and a bleak outlook on life appears to be evident:

1. lack of wholeness

2. sense of hopelessness/depletion

The experience of the therapeutic process. This major theme is defined as the participants' subjective feelings, perceptions and thoughts during the therapeutic passage. The following sub-themes are outlined in the order in which they were experienced during the therapeutic process:

1. difficulty engaging in the therapeutic process
2. inner turmoil
3. passage through the impasse
4. sense of safety in the therapeutic environment
5. development of trust
6. formation of a positive therapeutic relationship with the therapist
7. being inspired by their therapist
8. willingness to engage in the therapeutic process
9. sense of relief after sharing their pain
10. appreciation of the therapist

The experience of self discovery and self actualization. Self-actualization is defined as a revitalization resulting from becoming aware of feelings or knowledge about self and the expression of these in a spontaneous manner. This theme included the following sub-themes:

1. sense of freedom to become genuine

2. willingness to risk

The experience of belonging/fulfillment or raison d'être [reason for being/purpose]. This major theme refers to the participants becoming more aware of values, needs, beliefs and feelings that they decided to pursue and fulfil in their lives. This theme included the following sub-themes:

1. sense of purpose
2. preciousness of life
3. discovery of their own needs.

The Experience of Self

Lack of wholeness. All participants reported feeling "a lack of wholeness" due to their loss. Chantelle was totally consumed by the pain of her grief. This was clearly evident in the following disclosure, "I just ... it felt that someone had ripped my heart out ... stomped on it."

Amanda was able to express her loss of self more explicitly in the following statement, "I guess one of the first things I said to Beth [therapist] was that I really wanted to find who Amanda was." Then she goes on to say, "At first it was based on my grief and I guess it still is to a certain extent but it's also grief for losing my identity."

Lewis reported that there must have been something intrinsically different about him, as indicated in the following quotation, "basically ... there [is]

something wrong with me. That [is] probably the most compelling feeling I had ... personally being a failure ..." This was one of the central issues that dominated his train of thought as he began his therapeutic work with his therapist.

Sophie reported feeling her whole life fall apart when her daughter was killed, "... my whole life was shattered into a zillion pieces." She also reported feeling totally powerless, which was compounded by the fact that she was initially unable to find a therapist who would help her through the pain of her grief.

Sense of hopelessness/depletion. All participants also reported feeling a deep sense of hopelessness. This was particularly evident with Sophie who reported feeling that there was no point in living without her daughter. She was so discouraged that she contemplated suicide many times. She reported, "You just want to die. What's the point of living when someone so precious that you are living for has been taken away from you?"

Chantelle reported feeling somehow "orphaned" by the loss of her mother who was her confidante and her friend. She, too, found herself thinking of suicide as an option because of the pain of her grief. She reported, "you think that you want to give up because it hurts so bad, think you can't take it anymore, you can't seem to readjust." Her sense of aloneness was compounded

by the fact that she had spent most of her life in the service of others. She also mentioned that she was "... just like my Mother who was also always caring for others."

Lewis reported feeling totally lost, which is clearly evident in the following passage, "... I didn't know how it looked on the outside [to other people] but it looked ... when I think about it, at times, so chaotic." He also commented on feeling very depleted because he had spent his whole life attempting to meet others' needs at the expense of losing a sense of his own needs.

Depletion was also reported by Amanda, "I had nothing to give ... I was emotionally drained and so I had all these things that I sort of dumped on Beth [therapist] too, and I didn't know how to handle it all." She reported feeling burdened by the responsibilities of caring for her family, as she had spent her whole adult life taking care of others' needs. Perhaps one of the most touching passages, which clearly reflects this woman's feeling of aloneness, hopelessness and her own need for love and support in the world, is the following, "I just wanted someone to put [their] arms around me and envelope me and look after me."

The Experience of the Therapeutic Processes

Difficulty engaging in the therapeutic process. After the initial session, all the participants reported feeling a sense of hope because they "had found the right person." They reported that their therapist truly understood their sorrow. However, each participant experienced difficulty engaging in the therapeutic process. For instance, Chantelle stated, "We tried visualization for a while, [but] it didn't work very well ... I don't have good enough self-esteem to deal with a lot ... that was trying to make me feel better. I have a hard time with that, kind of avoided that."

When Lewis entered therapy, he reported ambivalence in entering this relationship due to his wife's disapproval of therapy. He reported feeling overwhelmed by emotions that were "childlike" which is evident in the following passage "... a lot of the raw emotions of that time because I guess I couldn't quite articulate them. They were very I guess childlike feelings that I had ... but I didn't feel like a man because of this childlike emotions that had been suppressed for so long ..."

Sophie reported feeling extremely drained and wanted to escape, rather than continuing this painful exploration. She recalled her therapist asking "a lot of unpleasant things that you wanted to talk about, but know one else would ever let you." This also indicates the isolation that this woman

experienced, Sophie reported that no one allowed her to discuss her grief, nor did she feel comfortable reaching out to others.

Amanda sheds more light on her difficult process of engaging in therapy. "For me, I think the first few months or first while at counselling was really difficult. I didn't feel comfortable opening up. It was not a normal thing for me at all." Amanda reported feeling that she was betraying her husband because he was not there to defend himself. She was also haunted by memories of her husband's disapproval of therapy.

Inner turmoil. Along with the above, each participant experienced a great deal of inner turmoil in their process of recovery. Amanda describes this process as, "I guess there were a lot of emotions other than the actual death and grief that I was feeling and I think that partly in most cases there's a lot of unfinished business especially in a sudden death." Another issue that troubled Amanda was her lack of opportunity to resolve her differences with her husband.

Chantelle also struggled through this difficult process. She recalled some of the sessions where her therapist attempted to move deeper into her experience, "Oh God, one of the big things was like she kept wanting to work on you with memories and memories and all I could remember was memories of the last moments. Mom dying, dead Mom, and Mom being dead in a casket

and putting Mom in the ground, and I couldn't get over that." This young woman was clinging to her mother and could not move beyond the actual death scene for a long time.

Sophie recalled her therapist pointing out her choices at the beginning of therapy, "Now your life has been smashed into a million and one pieces. How are you going to glue yourself back together? Is it going to be with bitterness and hatred or is it going to be love and compassion?" Sophie was only aware of her anger at the world, and had a great deal of difficulty moving beyond this for a long time.

Rationally, Lewis knew he was quite successful in the world, but emotionally he felt devastated and very fragile as a result of the recent deaths. He recalled the following "I didn't feel that I could put the two halves together; the rational part of things and the emotional part of things." He described his experience in the following passage, "I couldn't quite put my finger on what it was, what was bothering me, and it was almost as if I was detached in some ways."

Passage through impasse. As time went by, they were able to form a positive therapeutic relationship. They all reported feeling a growing sense of trust in their therapists. A sense of trust was clearly evident in Chantelle's experience with her therapist, where she describes the following, "She's this

special person who pushes you where you don't want to go and at the same time you can trust implicitly with anything, with silly things that will help you push yourself to do things."

Lewis describes his need to have a therapist who is genuine, which is evident in the following passage "I didn't need sugar-coated pills, don't give me any smoke and mirrors or bells and whistles. Just give me the plain honest truth about things and he did it in such a way that they weren't put downs." Lewis's therapist created an environment that allowed trust to develop because of his ability to respect his client's needs.

Sophie reports her therapist's willingness to share herself which inspired a sense of trust and hope that she would herself recover. This was clearly evident in the following statement, "I mean we got to trust each other. I suppose ... and she would tell me a few of her personal problems too, but they always were things that were helping me at the same time. People helping people. It is pretty simple really."

Amanda describes the slow process of beginning to trust, as the relationship developed in the following statement, "I don't think it was suddenly a light came on, it was something that happened over a period of time and trust and all these things that it just was I suppose that if you give a little bit then the next time you give it doesn't seem as hard."

Sense of safety in therapeutic environment. Another key element that enabled the participants to engage in the therapeutic process was their therapists' ability to create a safe and trusting environment. Lewis made following comment in this regard, "I found by going there, I sort of felt safe. I could talk about how I felt."

Amanda felt a sense of safety and confidence in her therapist's abilities because of the therapist's own experience with the loss of her daughter. Another factor that instilled hope was her therapist's extensive work with the bereaved population.

Chantelle needed a great deal of reassurance from her doctor on the therapist's qualifications because of past negative experiences with a psychiatrist. This was clearly evident in the following passage, "I don't want to be medicated. I don't care to be medicated. I just need somewhere safe that I could talk ."

This young woman had a great need to be conscious of her journey to recovery. As she slowly move through the therapeutic process, she found that this was indeed a safe place for her, because her therapist was someone she could "count on".

Sophie saw her therapist as a "saviour". She also discovered that she could acknowledge her pain because in this environment, "I couldn't tell some

of my inner feelings just to anyone and, it was a safe place, a very safe place."

In the interview, she mentioned this several times, which would clearly indicate the importance she placed on being safe.

Development of trust. Another key point that enhanced the growing relationship with their therapists, was the participants feeling understood and accepted by their therapists. Amanda states the following, "Well I think that the thing for me was I felt finally like I could talk about my emotions. It was a non-judgemental type of thing."

Sophie recalled feeling totally accepted by her therapist, as she went through this difficult and painful process. She reported, "For the hour that I was there at least I was talking to someone else who understood what feelings I was experiencing."

Lewis also spoke of his therapist's acceptance of him as evident in the following statement, "Just for the fact that he was there and being empathetic and being non-judgmental, of him being who he was and allowing me to be who I was."

Chantelle recalled a session when she was deeply touched by her therapist's care, "The first time we hugged ... that was wonderful. That was like just like this aunt that helps you out, your favourite, when you're a kid who's safe, that kind of person you could talk about sex when you were a kid, but

couldn't talk to your Mom about. That's what a therapist is like." She also describes her therapist "as a special person with a big heart," which would suggest that Chantelle felt totally accepted.

Formation of positive therapeutic relationship. As the therapeutic relationship continued to grow, all participants felt a close and meaningful bond with their therapist. For instance, Amanda commented on her relationship, "It becomes a very close kind of relationship ... I feel good when I come out of it."

As Sophie struggled to be in the world, the only thing that offered her hope was the close bond she had developed with her therapist. She describes this in the following passage, "I just looked forward to each meeting with her. I clung to it and just sort of functioned in between and yet when I'd go to her I'd be fine for the hour that I was there ..." She later stated that her therapist "allowed me to cry, to vent my anger. You can't do that in the outside world. Nobody will let you. ... Basically, I think, that's what she allowed me to do."

Once Lewis had gained greater self-confidence, he found himself recalling his time with his therapist, which enabled him to sort out problems on his own. The following statement clearly indicates the effects of a positive therapeutic bond and how he had merged with his therapist, "I imagine myself being in the counselling situation or focusing on things that James [therapist] had said in the past or had written down and I would approach

the present crisis from that point of view and struggling to deal with them and understand them."

Chantelle reported that the therapeutic alliance enabled her to "heal herself." This is evident in the following statement, "In the end if something happened ... I went back again. I wouldn't hold anything back because the relationship was such that you'd laid it all on the table by now."

Being inspired by their therapist. The key thing that helped these individuals engage in the therapeutic process was the inspiration their therapist offered. Sophie looked to her therapist as a role model, which is clearly evident in the following passage: "Yes, she had survived. And she had put her life together and how she carried on the rest of her life was to help other parents who had been in the same position ... That's how she made meaning out of her little girl's death. It gave me some confidence that there was going to be a light at the end of tunnel."

Being overwhelmed by the image of her mother's death, Chantelle found herself wondering if she would indeed recover from the pain of her loss. The therapist's ability to inspire hope of recovery was evident in the following, "... what Connie had said, was that the continual, recurrent ... vision of seeing the actual moment of death and that the very closely associated moments of that

directly before and directly after was something that could go on until I'd come to accept the fact that she was dead."

In the midst of his chaos, Lewis found his therapist's sense of presence very encouraging, "He was never negative about things. But he could convey to me a sense of dealing with those kinds of devastating things that were going on with me and in a way that was okay. It was okay to feel that way."

In her struggle to make sense of her grief, Amanda also found her therapist's presence played an important role in allowing her to go deeper into herself. This permitted her "to look inside [herself] and to say things and to say things without anyone judging or feeling guilty but that took time."

Willingness to engage in therapeutic process. Once the participants had a safe and trusting therapeutic environment, they were receptive to their therapists' guidance, which enabled them to move deeper into their experience. Amanda made the following statement in this regard, "Beth kind of led me in on that, that was probably the break through of me beginning to realize that okay I'm an okay person. Yes I feel that, and yes I can see how things worked on both sides, and I can see that's where I'm getting to now." Another key ingredient was the guidance she received from her therapist, who supported and encouraged her to bury her husband's ashes. The participation of this ritual allowed Amanda to begin the process of letting go of her husband.

Chantelle also found her therapist's guidance instrumental in helping her explore problematic issues. This is clearly evident in the following "I mean like, what Connie sort of did, you worked on one hurdle and then your work on the second hurdle." The therapist's guidance allowed Chantelle to gain a sense of control. Chantelle also recalled her therapist's continual encouragement to take care of herself, but more importantly, her therapist's enthusiasm "... to every positive step you take, being told you're special every now and again."

Sophie recalled her therapist's guidance, as she struggled to deal with conflicts within her family, "Beth really helped through that a lot. Just pointing out that what I was doing was the right way to go, don't bow to these people, they haven't learned what life is all about so because I did feel guilty at times, and Beth helped me. She said there is only so far you can go and people have to make their own decisions which way you want to go in life. And she said to me you are just going to be beating your head against a brick wall, don't you think you have been beat up enough." The therapist's guidance allowed Sophie to move beyond her guilt and slowly learn to take care of her own needs.

Lewis noted that "James just being able to focus in on what he perceived to be some of the issues and help me bring them out in the open and confirm them." Another intervention that proved to be very helpful was his therapist writing "... a sort of synopsis of, in a sentence or two, of a lot of things I had

experienced, not only through our counselling but a lot of other things in my life." The written notes allowed him to reflect upon his situation in more depth, between the sessions.

Sense of relief after sharing their pain. Through this slow process of exploration, the participants reported experiencing a sense of relief, after uncovering and disclosing their pain and dealing with the unfinished business associated with their loss. This is clearly evident in Amanda's statement, "But I found it very relieving going to Beth because gradually I learned to say things sort of like ... I remember saying to her, finally, I guess I felt as though I was in a box and finally I could see out a little bit."

Chantelle commented that at the end of many sessions, "... like I use to leave (sighs) take an actual deep sigh and say, lots off my chest today and go home and then be happy again."

As Sophie worked her way through her grief, she experienced a great deal of relief and freedom to express herself, which is clearly evident in the following statement "... except that she was someone I could look forward to seeing once a month and dumping on."

As Lewis moved deeper into the therapeutic process, he felt relieved to come to terms with the past which is evident in the following passage, "Another aspect of the counselling was that once I was able to express those

feelings that I had and grieve for my mother and grieve for the loss of what her death meant to me and the loss of my father then it made it so much different. It made it so much more bearable. It didn't change anything. It didn't make the reality any different, but what it did was help me accept and deal with it because that grieving had been denied to me."

Appreciation of their therapist. Each participant reported feeling a deep appreciation for their therapist. Amanda's comment, "I did find that it was a wonderful experience for me. It's just ... I'll be in the kitchen and I'll be thinking and oh, that's how that all worked and happened and I don't think that I'd have come to that stage without [someone] leading or helping me to get into thinking that way." What I believe Amanda is saying is that her therapist probably by modelling reflective thinking and insight through awareness, helped her to spontaneously begin to do the same thing on her own.

Similarly, towards the end of therapy, Sophie had recalled how much she had grown through her very special relationship with her therapist. She saw her therapist as a friend as well as a professional.

Chantelle reported feeling very fortunate because her therapist extended herself. She went on to say, "Connie, given the kind of person she is, she does what she does because she actually cares and she's always been the kind of person that I could count on."

Towards the end of therapy, Lewis recalled the following, "I guess a sense of more respect for James and who he is and what he does. A lot of respect for him. A lot of respect for the role that he plays and it's done in such a humanistic way." He then goes on to say, "He basically allowed me to be me and allowed me the power within me to heal myself if you wish. That's probably the best way to put it." This, in turn, allowed Lewis to discover his own inner strength.

The Experience of Self Discovery and Self-Actualization

Sense of freedom to become genuine. As these individual let go of their pain, they discovered a new found freedom to express themselves. This is clearly apparent in Chantelle's statement "... where with your therapist, you just go in and talk and laugh if you want to, you cry if you want to cry and ... it's a free place to be and a free place to express whatever you're saying. It's a free place to express your anger." Therapy became a place where she could be herself and not have to put on an act.

Amanda also gave herself permission to express herself, which was evident in the following, "but here I can let everything out and it just felt so good just to be able to talk."

Lewis found a freedom within the therapeutic process, that he reported that he had long denied himself, "James allowed me to be me, and that was

probably the single greatest thing about that whole experience was that he allowed me to be me without imposing any other preconceived notions on me."

Gradually, Sophie was able to move beyond her anger and hatred over the unfairness of her daughter's untimely death. One of the key things that helped her through this difficult process was becoming involved with the Compassionate Friends group, where she shared her pain with other parents. At first, she felt that she was the only one who had experienced a great tragedy, but as time went by she discovered others' pain.

After Lewis had a greater awareness and acceptance of his emotions, he found himself willing to share his inner most thoughts and feelings with his wife, without fear of being rejected or ridiculed.

Willingness to risk. As Amanda moved through the therapeutic process, she gradually began to reach out to her daughters and was willing to be more sincere, and to seek support from them. Her ability to reach out and share with her daughters is evident in the following passage, "These are my feelings that I am now learning to express. I am learning to ask for things which I've never done before."

Once Chantelle had formed a positive relationship with her therapist, she had the courage to reach out to another human being, with whom she formed a strong bond. She also discovered that she could no longer pretend, she had to

be honest within the therapeutic process, if she was to be healed. Chantelle also discovered how she had changed, through this difficult and painful process, which is clearly evident in the following passage, "I'm a lot more open about how I feel with all emotions. I used to acknowledged sad and happy things, but anger was not something that I acknowledged very well." Along with this, Chantelle came to accept herself and others, which is seen in the following statement, "I'm a lot less judgemental on myself and other people now ..."

The above clearly indicates the participants' willingness to become more genuine. This newfound sense of self is also evident in Lewis' comment, "Then I was on my own. That was what I needed. For me to be able to say that and be that for myself and not for it to come from anywhere else outside of myself, but for me to come on my own to recognize those things and to say them and feel them and mean them. I guess that was the single biggest thing. That's when I also knew that counselling was coming to an end." Once he had accomplished this, Lewis was able to accept those negative feelings he had long denied. He also reported feeling more comfortable with his wife because he could share his feelings more openly.

Chantelle also realized that she needed to be open in order to go through this difficult process, in the following statement, "Knowing that I had to be

honest if I wanted to heal." She commented that she had to struggle to maintain this stance because of the pain of her grief.

Amanda commented on the following, "I find that I feel much more honest, more aware, and much more relaxed by the pressures and I don't know what else to really say. It's a great feeling."

After the tragic loss of one child, Sophie became extremely over-protective of her surviving son. She found herself holding back any form of criticism because of her fear of another loss. However, as time went by, Sophie found herself being frustrated by her son's inability to conform with her standards. Slowly, Sophie had the courage to verbalize her negative feelings towards her son, which allowed her to become more open and genuine with other members of her immediate family.

The Experience of Belonging/Fulfillment

Sense of purpose. As the participants gained a greater sense of their own inner strength, they gradually discovered new meaning in their lives. Lewis realized that the college environment was very restrictive. He invested a lot of energy in his family business because this was "more personally satisfying because I would have more control over the environment."

Through the support and encouragement of her therapist, Sophie gained a sense of purpose and meaning through her commitment to help other parents,

who had lost a child. She had a deep need (a mission) to develop resources for the bereaved because she did not want anyone to experience the pain that she had encountered.

Chantelle also was driven to find meaning in her life. After her long search, she rediscovered her love for children, "That made the difference all of a sudden being whole again, doing something that you love and helping someone else in the process, being where you belong, brings everything together, something you've experienced in the past ... then it helps come together."

Amanda found a sense of purpose through her volunteer work with Victim's Witness Assistance Program. She felt that she could also help other widows who had experienced sudden loss because she understood their struggle to make sense of grief.

Preciousness of life. After many years of neglecting his emotions and the needs of his family, Lewis realized that he wanted more meaningful contact with his wife and young daughter. After working out his differences with his wife, Lewis discovered the preciousness of his family.

As Sophie struggled to make sense of her daughter's tragic loss, she was unable to see any beauty in life. But slowly she rediscovered the beauty of nature and the preciousness of her family.

Chantelle was also acutely aware of the preciousness of life, as she saw friends interact with their mothers. This was a constant source of pain and a reminder of her loss. Slowly, Chantelle began to rediscover the preciousness of life through her work.

Amanda also found herself enjoying the preciousness in her everyday interactions with others. Along with this, she found herself taking time to "... sit back and smell the roses a bit more now and accept people for what they are and accept and enjoy time spent with people ..."

Discovery of their own needs. Along with the above, each participant became acutely aware of their need to take care of their own needs. After dedicating all of her energy to other's needs, Chantelle commented on the following, "There's always time for me now, for the first time in my life ... give to myself I always have to keep that part that I need and I know how to take it now. That's completely new ..."

Lewis came to this insight, " ... to be much more benevolent to myself and to be more caring and nurturing of myself because I have to look after those things for myself." He also realized that he was not "... going to put [himself] so far out that there's nothing left for [him] to hang on to."

Amanda found herself contemplating about another relationship, but

I know that I have found that in me and I couldn't settle for not having it and feeling free to say what I feel because it's very important that I'm suddenly starting to do that and I don't want to shut that door again."

After the long process of dealing with the conflicts of the family business, Sophie realized that "It's okay to take care of ... [herself] again instead of others at this point." This was evident in her recent decision to resign from her position in the Compassionate Friends group, where she had dedicated all of her energy. Sophie now feels that she would like to take time to enjoy her family.

Conclusion

In conclusion, the participants in this study were initially totally overwhelmed by the pain of their grief. This greatly influenced their level of involvement in the initial phase of therapy. They all experienced difficulty in engaging in the therapeutic process. Through the formation of a meaningful relationship with their therapists, they slowly had the courage to face their loss. In the end, they discovered several things, such as: a sense of freedom to be themselves, discovery of their own unique needs and their need to create meaning in their lives.

CHAPTER FIVE

Discussion

The purpose of this study was to explore the bereaved individuals' experience of counselling. The research question was "How do bereaved individuals experience therapy while going through the grief process?" In this chapter, we will review the following: a summary of the participant's therapeutic experiences; a comparison of their grief experience to the literature on grief; a comparison of recovery process on grief; a comparison of their experience of counselling to the counselling literature; the limitations of this study; the implications for future research and counselling; and the meaning of this study for the investigator.

The Bereaved Individuals' Experiences of the Therapeutic Process

The participants discussed several issues around the loss of a loved one, such as the circumstances around their tragedy and their reaction to their loss. However, the main focus of the interviews was exploration of the participants' therapeutic experiences. As the participants entered the therapeutic process, they felt totally consumed by their grief; they did not have a sense of wholeness due to their loss. Along with this, they experienced a deep sense of helplessness. Two of the participants contemplated suicide as an option to escape the pain of their grief. All the participants also experienced a sense of

depletion because they had always taken care of others' needs at the expense of their own needs.

Along with the above, all participants were initially reluctant to engage in the therapeutic process. They also struggled with the unfinished business around the deceased (that is, what was left unsaid or unresolved). The participants' struggle was compounded by the fact that they experienced guilt over their past actions, inactions, behaviours, and feelings towards the deceased. All participants experienced regret over lost opportunities with the deceased.

As the individuals began exploring the pain of their grief, they slowly allowed their therapist into their world. All the participants were able to form a deep and meaningful relationship with their therapist. The key ingredient that allowed this relationship to occur was the therapists' acceptance of the participants' disclosure. Along with this, the therapists were able to create a safe and trusting environment. As the therapists guided the participants into the painful memories of their past, the participants gained awareness and acknowledged their sorrow. This therapeutic exploration allowed the participants to discover and reclaim the emotions they had denied. All the participants found this exploration a very liberating experience. They also experienced a great sense of relief after disclosing and processing the unfinished business of the past. As they uncovered and reclaimed their past, they had the

courage to risk being themselves with significant others. Along with the courage to risk, they began their search for meaning with the support and encouragement of their therapist. All the participants were able to find a sense of purpose and meaning in their lives, outside of the therapeutic relationship. Lastly, all the participants became acutely aware of the importance of caring for their needs.

Comparison to the Literature on Grief

According to Bowlby (1980) there are four specific phases in the grief process: numbness, searching, disorganization and despair, and reorganization. The latter two phases were clearly evident in this study's participants as they experienced a deep sense of helplessness on entering therapy.

As evidence of disorganization and despair, one participant felt totally lost because he had difficulty coping with feelings associated with his multiple losses. As stated previously two of the participants considered suicide because the pain of their grief was so intense. The last participant felt totally helpless without her husband.

Another theme that clearly corresponds with Bowlby's (1980) phase of disorganization is the "inner turmoil" that all the participants reported in their initial experiences of therapy. The participants were haunted by the deaths of their loved ones. Three participants had difficulty separating themselves from

the deceased. The fourth participant doubted his own mental state, as he thought he might be mentally ill.

In the reorganization phase, all the participants searched for new meaning in their lives. They all found their own unique ways of being in the world, without the deceased.

According to Cochran and Claspell (1987), there are four specific phases in the grieving process. In the first phase, the bereaved individuals experience a sense of depletion. The sense of depletion was noted in all of the participants, as they felt they had nothing to give to others. They had no awareness of their own needs.

Cochran and Claspell (1987) found that in the second phase, the bereaved individual had difficulty making meaningful contact with others. The participants in this study felt that no one could understand their pain. This sense of isolation was compounded by the fact that our society has little understanding of the grieving process.

In the third phase, the bereaved person searched for new ways of being in the world. Through the guidance and encouragement of their therapists, all the participants slowly were able to make more intimate contact with their significant others, and to find fulfilment in their work. One participant found a sense of purpose by becoming involved in Compassionate Friends, an

organization that offers ongoing support for bereaved parents. She had a mission to help other bereaved parents and to form a strong network of resources, so that other bereaved individuals would not have to experience the anguish that she had experienced because of a lack of resources. Another participant was able to form a deep and intimate bond with a new partner, through which she could honour her own needs. This participant also had a mission to find things that had previously made her feel good about herself. Eventually, she rediscovered her deep love for children and is currently studying to become a special needs assistant for handicapped children. The third participant also had a mission to honour his own needs and invest his energy in the family business. This allowed him to have more closer contact with his family. Most importantly, he became more genuine with them. As the fourth participant discovered a new found sense of self, she became aware of her need for meaningful contact with her daughters. She also discovered the importance of being aware of her emotions and expressing them. This participant also found a mission in being of service to other bereaved widows who had suffered the sudden loss of their loved ones.

In the fourth phase, there was a discovery of the preciousness of life. All the participants reported their new found discovery of the preciousness of life, their connection with nature and the importance of their current

life, their connection with nature and the importance of their current relationships. Cochran and Caspell (1987) also noted that bereaved individuals in their sample discovered their own unique spiritual path. Three of the participants in this study did not report the importance of their spiritual growth. Only one participant found comfort in the Taoist teachings which helped her gain a greater awareness and acceptance of her emotions.

According to Brice (1991) bereaved mothers who experience sudden loss do not go through their grief in an orderly manner. One of the participants in this study suffered the sudden loss of her daughter. She reported that there was lack of predictability in her grieving process. This participant never completely accepted the finality of her daughter's death, as she somehow was left with the feeling of "lack of wholeness". This finding corresponds to Brice's (1991) findings, in that the bereaved mothers' experience their dead child as part of themselves.

In conclusion, the findings in this study are similar to the literature on the grieving process. The results differ in that not all the participants in this study reported the importance of their spiritual growth.

Comparison to the Literature on the Recovery Process on Grief

According to Parks and Weiss (1983), there are three specific tasks for the successful resolution of the grieving process. The first is the intellectual

acceptance of the death of a loved one. This acceptance was found in all of the participants. Their therapists played a key role in accomplishing this task. For instance, through the therapist's support and guidance, one participant buried her husband's ashes. As a result, the participant slowly accepted her loss. The other participants were better able to face their loss and come to an acceptance of that reality by exploring the circumstances around the death.

The second task according to Parks and Weiss (1983) is the emotional acceptance of the bereaved person's loss. Through the painful process of exploring their emotions around their loss, all the participants were slowly able to express their sorrow over the death of their loved one. The participants were filled with regret over lost opportunities and unfinished business around the deceased. Eventually, as a consequence of the therapist's patient guidance, the participants were able to honour their feelings. All the participants expressed the importance of being genuine. Even more difficult feelings such as anger towards the deceased just surfaced and were accepted. The permission-giving atmosphere created by the therapist as well as the therapist's acceptance of the client, aided them in being able to explore and express what were heretofore seen as "negative emotions."

The third task is the formation of a new identity without the deceased.

As the participants accomplished the above tasks, they became acutely aware of their own needs, and values, some of which were different from the deceased.

Worden's (1982) task model is similar to Parks and Weiss' (1983) model. Tasks one and two in these two models have much in common. For instance, in Worden's (1982) first task, the bereaved need to acknowledge the reality of their loss, which corresponds to the Parks and Weiss (1983) intellectual acceptance of the loss. In Worden's (1982) second task, the bereaved need to experience the pain of their loss. Again this is similar to Parks and Weiss' (1983) emotional acceptance of the loss. Therefore the findings cited earlier illustrate Worden's (1982) model.

In the third task, which differs from Parks and Weiss (1983), the bereaved individuals' need to adjust to their environment without the deceased. Through their therapists' patient guidance and encouragement, the participants became aware of their own needs and began to take risks.

In the last task, the bereaved individuals' need to withdraw their emotional energy around the deceased and re-invest this energy in other relationships. This was clearly evident in the participants in this study, for they were able to form deep and meaningful relationships with their immediate family, or in a new relationship. For instance, three of the participants reported

being more "genuine" and "accepting" of their family. The fourth participant also took great pride in her ability to relate more openly with her new partner.

One unusual finding that is not mentioned in the existing literature on the recovery process was the fact that all the participants defined themselves as "people helpers", who often acted in the service of others. Their sense of meaning, purpose and function was derived from these acts. In short, their identity was defined as a "server to others" at the expense of their own needs. Their major identity was invested in service of others. They recognized and accepted themselves as "caregivers". It was not only in their service to the "beloved departed" that they felt they acted as "caregivers" but to those in their immediate family or to people in the world at large.

When confronted by the loss of their loved one, whom they cared for, these participants gave up their caregiving function towards others in their immediate family. They suffered a sense of purposelessness, meaninglessness and loss of sense of self. These may have transpired because they were overwhelmed by their grief, or it may have been that part of how they saw themselves died when their loved one died, that is, their sense of worth derived from serving others was no longer apparent. It may be that the participants withdrew from their service of others because they were left bereft by the deceased and feared being left again. Or they may have withdrawn from a

sense of anger or hurt. In any case, during their grief process they needed support to find themselves again, to feel whole and worthwhile and to find fulfilment in their lives.

The participants had to reach deep within themselves (with the help of a skilled therapist) to find new meaning. Their identity crisis was resolved by coming to a deeper understanding or acceptance of their own needs. Often, at the end of their therapeutic experiences, they found a new direction. In other words, they had found a new sense of themselves; one which was less dependent upon the need to "serve others" and more to serve the "self". In the process of discovering their new sense of self, the participants became more self-directive. After completing their therapeutic work, the participants still cared for others, but they had a much deeper appreciation of their own needs and gave themselves a lot more space to be true to their own desires in their relationships with others. In short, they were more aware of themselves and more self-expressive in their significant relationships.

In summary, the participants' movement through the different tasks of grief correspond to the existing literature on the recovery process (Parkes & Weiss, 1983; Worden, 1982). One finding that differs from the existing literature is the characteristic of being a "caregiver" where prior to the death of loved one, the individual had a great need to meet both the deceased's and other

people's needs. The end result is that the participants did not have an awareness of their own needs. Through the recovery process, these individuals were able to integrate their own needs with the needs of others thereby finding a new meaning in caregiving.

Comparison to the Counselling Literature

The participants' descriptions of their therapeutic experiences correspond to those reported by Rando (1993). First, Rando states that bereaved individuals normally experience a great deal of resistance in engaging in the therapeutic process. There are two possible reasons for this stance: their fear of being totally overwhelmed by the pain of their grief or their fear of another loss. Initially, all the participants had difficulty engaging in the therapeutic process because they were overwhelmed by the pain of their grief. All the participants experienced the sudden loss of a loved one. They did not have an opportunity to prepare themselves psychologically. One participant was tormented with feelings of "guilt" because she somehow felt responsible for the death of her loved one. Another participant suffered with feelings of "guilt" because she did not have an opportunity to resolve her differences with her husband before his untimely death. One participant was extremely "angry" at the person who was responsible for her daughter's death. The fourth participant was overwhelmed by the trauma of multiple deaths, which had occurred within six months.

Second, according to Rando (1993) the key factor that allowed the participants to slowly engage in the therapeutic process was their therapists' sense of "presence", as this indicates that the therapist has made a commitment to support the client through the painful process. One participant felt his therapist's sense of presence motivated him to take responsibility for his "healing". Two participants, with a history of negative experiences with psychiatrists, were relieved to find their therapist was truly there for them. This experience gave them hope that they would be able to deal with the problematic issues that haunted them. But more importantly, the therapeutic environment allowed them to take a more active role in their recovery process. The last participant found her therapist instilled hope that she was not alone any longer. The therapists' presence allowed the participants to move through their impasse.

Third, the therapist's ability to give the participants "permission" to grieve their loss is another critical factor in the recovery process. According to Rando (1993), the therapist needs to be open, interested and nonjudgmental allowing the bereaved individual to move deeper into the therapeutic process. All the participants experienced their therapist as having the above qualities. Through the therapeutic exploration the participants became aware of the emotions they had repressed and they were able to take ownership of these emotions, as they dealt with the unfinished business of the past.

Slowly, the participants gained an awareness of the positive and negative qualities of the deceased. This was particularly evident in three for the participants in this study as they gained a greater awareness and appreciation of the deceased. Unfortunately, the participant whose daughter was killed could not process those deeper emotions surrounding her daughter because of her inability to move beyond her hatred towards the man responsible for this death. This participant used drugs and alcohol to cope with her loss, which prevented her from recovering as quickly as the others.

Fourth, according to Rando (1993) timing plays a critical role in helping the bereaved move beyond their resistance to exploring painful past experiences. All the participants found their therapists were very effective in guiding them into areas that needed exploration. Two participants found their therapists' timing allowed them to move deeper into their experiences. The other two participants found their therapists' directives too threatening at the beginning of their therapeutic experiences.

Fifth, the therapist's credibility also played an important factor in instilling a sense of confidence in the participant's experiences. For instance, one participant felt that she could "count" on her therapist to be there for her. The therapist's reliability was particularly important because this participant had been suicidal while in therapy. She needed to be assured that her therapist

would be available in those painful hours. Another participant found his therapist was always "consistent", which gave him a sense of predictability and "grounding" in reality. The two other participants, who saw the same therapist, felt their therapists' own experience with the death of her daughter, made her more credible. But more importantly, this served to instill hope of their own recovery because the therapist was living proof that one indeed survives the pain of grief. The above corresponds with Rando (1993) who stressed the importance of the therapist's ability to create some predicability for their client. It was also a means of creating a sense of safety for the clients.

Sixth, Rando (1993) stresses the importance of "perseverance", which means the therapist's ability to see the treatment through to the end. The researcher was struck by the therapists' deep commitment to their clients. For instance, one participant reported that her therapist scheduled the appointments for the end of the day so that the client would not have to be under time constraints. This was particularly important in the initial phase of therapy, as this young woman had difficulty trusting in the therapeutic process. The therapist's ability to extend themselves in this manner may enhance the building of a positive therapeutic alliance. Therapists' ability to be creative in their interventions also enhances the therapeutic relationship and the depth of therapeutic work (Rando, 1993). This was confirmed by all the participants,

who were able to rediscover themselves and find a sense of fulfilment and belonging in their lives.

The above findings are very similar to Worden's (1982) in that three participants were able to separate themselves from the deceased. They accomplished this by being able to identify both the positive and negative aspects of their relationship with the deceased. They were successful in letting go of the deceased and forming meaningful relationships with others. According to Worden (1982) the latter is an indication that the bereaved individual has indeed completed the essential tasks of the grieving process.

Reeves (1989) who did a phenomenological study of the therapeutic effects of rituals, was able to identify five specific themes in the participants' transformative process: anxiety, meaning, choice, acceptance of reality, healing and growth. As stated previously the participants slowly gained an acceptance of their loss but more importantly they became aware of the personal growth they had gained through their therapeutic experiences. Through this process they had the courage to follow their dreams, such as, forming more meaningful relationships with significant others.

Limitations of the Study

There are several limitations to this study. First, this study used retrospective accounts of bereaved individuals' experiences of therapy. These

self reports are greatly affected by the individuals' ability to recall their painful experiences of therapy. Another factor is that the psychological trauma associated with sudden loss can greatly influence the participants' ability to recall their experiences accurately.

Second, there were only four participants in this study, therefore one cannot make any generalizations to others who have experienced sudden loss. This study did not include individuals who had lost a loved one through anticipated loss, suicide, homicide, or accidental loss where the body of the deceased was never recovered.

Third, the results from this study reflect the positive therapeutic experiences of bereaved individuals who were guided through their grief process by skilled therapists. In addition, the participants in this study were highly motivated to seek help in order to "heal" themselves. Different results may occur with individuals who are less motivated to seek help or treated by less effective therapists.

Fourth, the therapists referred those individuals who had positive therapeutic experience. This, in itself, biases the results of this study.

Lastly, the participants in this study represented a white middle class group. The study did not include individuals from other cultural backgrounds. It would be interesting, for example, to know how First Nations People's

experience therapy, as there is very little documented information available on this group.

Implications for Future Research

Rennie and his colleagues (Angus & Rennie, 1988; Rennie, 1989, 1990) have developed an alternative method of investigating the clients' subjective experience of therapy. These researchers had the participants listen audio-tapes of the therapeutic sessions to recall their experience of therapy. After completing this task, the researchers used a phenomenological and ground theory approach to analyze their data. According to Rennie (1990) this method of investigation allows the researcher to capture some of the subtle, covert aspects of the experiences of therapy. More importantly, this method allows the participants to gain a greater self awareness and deepen their experiences of therapy. This method of investigation would be a fruitful area to explore with bereaved individuals who participate in ongoing therapy.

Second, it may be interesting to isolate individuals who define themselves as "caregivers" and who experience the loss of a significant other. The researcher could clarify the hypothetical postulates regarding their transition to being focused on others to becoming more focused on themselves and their own needs. The investigator may be able to identify the specific factors that aid these individuals to move through the transition from "caregiver" to "service to

self". This information may have relevance for future studies in "identity oriented research" or on implications for therapeutic approaches in working with "caregivers" who have no awareness of their own needs.

Another area that deserves further investigation is the difference between those who experience sudden loss to those who experience loss after a lengthy illness of their loved one. Such dramatic differences in the context in which death occurs may well impact how one processes their experiences of therapy, or makes a success of therapy.

Implications for Counselling and Therapy

Clinicians need to have a thorough understanding of the grieving process and the possible complications, (such as suicide, physical illness and so forth) that might arise as bereaved individuals go through this difficult and time-consuming process. All participants in this study reported feeling overwhelmed by the pain of their grief as they entered their therapeutic process. They had a tendency to withdraw from the world and a propensity towards hopelessness and depression. Therefore, the therapeutic environment needs to be a safe one where the therapist encourages the client to open up and share their feelings, thereby taking a first step towards re-entry into the world. By sharing their feelings with their therapists, the clients may make contact with their true self beneath their depression and come out of their withdrawal. The most

compelling need for these individuals was to have someone who truly understood their sorrow.

All participants reported that their therapist was able to instill hope of their recovery. This was accomplished by their therapist's ability to provide accurate information on the grieving process to their clients, so that they had a framework within which they could appreciate their experience. This, in turn, gave the participants a sense of hope that they would indeed survive their tragedy.

In the initial phase of therapy, all participants had a great deal of difficulty engaging in the therapeutic process. Clinicians need to be sensitive to their clients' ambivalent feelings (eagerness and resistance) about engaging in therapy. Strategies that allow the clients to move beyond their resistance need to be developed.

The participants in this study emphasized the importance of their therapist's total acceptance of them because they had a lack of trust in themselves. Clinicians need to be able to be empathic towards their clients' struggle to process the more difficult emotions associated with their grief. The clinicians' unconditional acceptance of their client, enhances the client's ability to be open and share their feelings. The client's ability to be open to their

feelings is an essential step in their recovery. The participants also reported a deep appreciation of their therapist's nonjudgmental attitude.

All participants reported the importance of their therapist's ability to guide them into painful areas, using counselling skills, such as active listening, paraphrasing, which is critical to helping bereaved individuals move deeper into the therapeutic process.

Clinicians need to be aware of each client's uniqueness. For instance, if the client has the tendency to intellectualize their experiences, but is unaware of their emotions, the therapist needs to help this individual find a balance between their emotion and intellect. All participants in this study stressed the importance of awareness and ownership to their feelings, thus they became more honest with themselves as well as to others in their lives.

Therapists need to be cognizant of the different therapeutic interventions which are needed in the area of bereavement. For example, one participant found the therapist's summaries allowed him to gain greater awareness of his own needs and later to communicate these needs to his partner. Another therapeutic intervention that proved to be beneficial was the creation of a photo-album of the past events with the deceased. This intervention allowed the participant to process her thoughts and feelings around her loss and come to a greater acceptance of her reality. Still another intervention that proved to be

useful was having the client complete a project that she had started with her mother. On a symbolic (unconscious) level this allowed the individual to let go of the deceased. An eclectic approach may be a viable alternative because of the uniqueness of each person's method of resolving their grief (Rando, 1993).

Permission-giving was another skill that the participants appreciated about their therapist. Participants were encouraged to grieve the loss and to learn to take care of one's own needs. This was a difficult task to achieve because of their tendency to take care of others' needs, rather than their own. At the end of their therapeutic experiences, these individuals were very much aware of their needs and able to act on these in their everyday interactions with others.

Another important intervention is helping the bereaved individual rediscover some meaning to their lives outside the therapeutic setting. Two participants stressed the importance of having extra support from their therapist's encouragement in helping them make a commitment to an area of exploration which reflected their values and needs.

In conclusion, there are critical factors in the therapeutic relationship that allow the bereaved individual to move through their grief: a sense of trust, a sense of safety and a sense of hope that the individual will recover from their

loss. Individuals will only benefit with the above factors in place, although specific techniques and therapeutic models may differ.

Meaning of this Study for the Investigator

One of the main reasons for undertaking this investigation was to gain a deeper understanding of the bereaved individuals' experiences of therapy, so that I could be more effective in meeting the needs of my clients. The findings have given me clear guidelines for accomplishing this task which I feel will be very useful in my work with Canadian Natives who have experienced traumatic loss of a loved one. For instance, many of these individuals have ambivalent feelings towards therapists because of negative experiences with other professionals, or lack of support from family and friends to enter this time consuming process. Therefore, I would need to have the patience to work through their initial reluctance to engage in the therapeutic process. Another point that comes to mind is the need to pace myself to my clients' needs rather than having a specific plan of action.

After spending four to six hours with each participant, I was deeply aware of their pain, but more importantly their motivation to recover. I was also touched by their ability to accept themselves and others. They all had a great need to share their experiences, with the hope that other bereaved

individuals would benefit from them. Their sense of optimism was a great source of inspiration for the investigator.

This study has shown me the power of a positive therapeutic experience. As the participants moved through the pain of their grief, they found a sense of belonging and fulfilment in their lives. The key ingredient that allowed these individuals make the discoveries was: the therapists sense of understanding of their sorrow; the therapist's skills such as, unconditional acceptance of the client's uniqueness; and creation of a safe and trusting environment. Through this therapeutic experience, the participants had the courage to risk facing their pain and being themselves.

References

- Angus, L. E., & Rennie, D. L. (1989). Envisioning the representational world: The client's experience of metaphoric expression in psychotherapy. Psychotherapy, 26, 372-379.
- Bowlby, J. (1980). Attachment and loss: Loss, sadness depression. (Vol III). New York: Basic Books.
- Brice, C. W. (1991). What forever means: An empirical existential-phenomenological investigation of maternal mourning. Journal of Phenomenological Psychology, 22, 16-38.
- Cochran, L., & Claspell, E. (1987). The meaning of grief: A dramaturgical approach to understanding emotion. New York: Greenwood Press.
- Constantino, R. E. (1988). Comparison of two group interventions for the bereaved. Image: Journal of Nursing Scholarship, 20, 83-87b.
- Dershimer, R. A. (1990). Counselling the bereaved. New York; Pergamon Press.
- Freud, S. (1934). Mourning and melancholia. In J. Strachey (Ed. and Trans.), The standard edition of the complete works of Sigmund Freud (Vol.13). London: Hogarth Press. 1934.(Original work published 1917).
- Giorgi, A. (Ed.) (1985). Phenomenology and psychological research. Pittsburgh, PA: Duquesne University Press.
- Giorgi, A. (1989). Some theoretical and practical issues regarding the phenomenological method. Saybrook Review, 7, 71-85.
- Horowitz, M., Wilner, N., Marmar, C., & Krupnick, J. (1980). Pathological grief and the activation of latent self-images. The American Journal of Psychiatry, 137, 1157-1162.
- Kast, V. (1988). A time to mourn: Growing through the grief process. Daimon, Germany: Verlag.
- Knapp, R. (1986). Beyond endurance: When a child dies. New York: Schocken Books.
- Kubler-Ross, E. (1969). On death and dying. New York: Macmillan Press.
- Manthorpe, T. D. (1987). Holding hands and resolving grief. The Australian Journal of Clinical Hypnotherapy and Hypnosis, 8, 1-6.

- Mawson, D., Marks, I. M., Ramm, L., & Stern, R. S. (1981). Guided mourning for morbid grief: A controlled study. British Journal of Psychiatry, 138, 185-193.
- McLeod, J. (1990). The client's experience of counselling and psychotherapy: A review of the research literature. In D. Mearns & W. Dryden, (Eds.), Experiences of counselling in action (pp. 1-19). London: Sage Publication.
- Melges, F. T., & DeMaso, D.R. (1980). Grief resolution therapy: Reliving, revising and revisiting. American Journal of Psychotherapy, 34, 51-61.
- Moran, M. R. (1988). A directed grieving paradigm for facilitating the mourning process and preventing abnormal grief response. Unpublished Dissertation, University of South Dakota.
- Osborne, J.W. (1990). Some basic existential-phenomenological research methodology for counsellors. Canadian Journal of Counselling, 24, 79-91.
- Osterweiss, M., Soloman, F., & Green, M. (Eds.). (1984). Bereavement: Reactions, consequences and care. Washington, D.C.: National Academy Press.
- Parkes, C. M. (1972). Bereavement: Studies of grief in adult life. New York; International Universities Press.
- Parkes, C. M. (1980). Bereavement counselling: Does it work? British Medical Journal, 281, 3-6.
- Parkes, C. M., & Weiss, R. S. (1983). Recovery from bereavement. New York: Basic Books Inc.
- Parkes, C. M. (1987-88). Research: Bereavement. Omega, 18, 365-337.
- Ramsay, R. W. (1979). Bereavement: A behavioral treatment of pathological grief. In P.O., Sjoden, S., Bates, & W.S., Dockens, (Eds.), Trends in behavior therapy. New York; Academic Press. (pp. 217-248).
- Rando, T. A. (1984). Grief, dying, and death: Clinical Interventions Interventions for Caregivers. Champaign, IL: Research Press Company.
- Rando, T. A. (1993). Treatment of complicated mourning. Champaign, IL: Research Press Company.
- Raphael, B. (1977). Preventative intervention with recently bereaved. Archives General Psychiatry, 34, 1450-1454.

- Reber, A. S. (1985). The Penguin dictionary of psychology. Harmondsworth, Middlesex, England; Penguin Books, Ltd.
- Reeves, N. C. (1989). Ritual as psychotherapeutic intervention for maladaptive grief: A phenomenological mapping. Unpublished Dissertation. University of Alberta.
- Rennie, D. L., Phillips, J. R., & Quartaro, G. K. (1988). Grounded theory: A promising approach to conceptualization in psychology. Canadian Psychology, 29, 139-150.
- Rennie, D. L. (1990). Toward a representation of the client's experience of the psychotherapy. In G. Lietaer, J. Rombauts & R. Van Balen (Eds.), 154-171. Client-centered and Experiential Psychotherapy in the Nineties. Leuven: Leuven University Press.
- Rennie, D. L. (in press) Qualitative analysis of the client's experience of psychotherapy: The unfolding of reflexivity. In S. Toukmanian & D. Rennie (Eds.), Psychotherapy Process Research (pp.2-31). Newbury Park, CA: Sage Publications.
- Rynearson, E. K. (1987). Psychotherapy of pathologic grief: Revisions and limitations. Psychiatric Clinics of North America, 10, 487-499.
- Schneider, J. (1984). Stress, loss and grief. Rockville, MD; Aspen Systems Corporation.
- Schneider, J. (1989). The transformative power of grief. Noetic Sciences Review, Fall, 26-31.
- Singh, B. & Raphael B. (1981). Postdisaster morbidity of the bereaved: A possible role for preventive psychiatry? The Journal of Nervous and Mental Disease, 169, 203-212.
- Sireling, L., Cohen, D., & Marks, I. (1988). Guided mourning for morbid grief: A controlled replication. Behavior Therapy, 19, 121-132.
- Sykes, J. B. (Ed.) (1976). The concise oxford dictionary of current English. London, England; Oxford University Press.
- Walls, N., & Meyers, A. (1985). Outcome in group treatments for bereavement: Experimental results and recommendations for clinical practice. International Journal of Mental Health, 13, 126-147.
- Worden, J. W. (1982). Grief counseling and grief therapy: A handbook for mental health practitioner. New York: Springer.
- Zisook, S., & DeVaul, R. A. (1983). Grief, unresolved grief, and depression. Psychosomatic, 42, 247-56.

Zisook, S., & Shuchter, S. (1986). The first four years widowhood. Psychiatric Annals, 16, 288-294.

APPENDIX A

TITLE OF PROJECT:

A PHENOMENOLOGICAL EXPLORATION OF BEREAVED
INDIVIDUALS' EXPERIENCE OF COUNSELLING

Dear _____:

The purpose of this letter is to inform you of my forthcoming study of bereaved individuals, who have resolved their loss through counselling; and to solicit your co-operation in carrying out this study. I am a M.A. candidate in the Department of Counselling Psychology at U.B.C. The present study will constitute a part of my M.A. thesis. My thesis supervisor is Dr. Richard Young, who is a faculty member in the department.

The purpose of this study is to explore the bereaved clients' experience of counselling. The study will consist of two interviews. The population that would be suitable for this study are: individuals under the age of 60; who have sought counselling for issues related to loss of loved one; who have terminated counselling within the last six to eighteen months having resolved their loss.

If you have any former clients who meet the above criteria, I would be most grateful if you would consider asking them if they would be interested in participating in this study. If they agree, please ask them to contact me at either numbers below.

If you have any question or concerns about this research, please feel free to contact either myself (733-4393 or 244-8433 after October 17, 1992) or Dr. Young (822-6380/822-5259).

Thank you.

Sincerely,

Alma Vaugeois
204 - 7411 Minoru Boulevard
Richmond, B.C.
V6Y 1Z3

APPENDIX B

Subject Consent Form

Title of Project:

A PHENOMENOLOGICAL EXPLORATION OF BEREAVED INDIVIDUALS' EXPERIENCE OF COUNSELLING

Principal Investigator: Alma Vaugeois

Thank you for your interest in my study. I am a M.A. candidate in the Department of Counselling Psychology at U.B.C. The present study is part of my M.A. thesis. I can be reached at 244-8433 or 590-4211, if you have any questions or concerns during this study. My supervisor is Dr. Richard A. Young, who is a faculty member of the Department of Counselling Psychology. He can be reached by telephone at 822-6380 or 822-5259.

The purpose of this study is to gain a greater understanding and awareness of your experience of counselling, after the loss of a loved one. The results of the study may shed some light on the process of grieving that would be helpful to others undergoing the loss of a significant person in their lives.

The study will consist of two confidential tape-recorded interviews, that will be approximately one and a half to two hours in length each. In the first interview I will be asking you to describe your thoughts and feelings around your experience of coming to terms with your loss through counselling. The material from this interview will be transcribed and analyzed for themes, within a few weeks after this meeting.

After approximately 4-8 weeks, you will be contacted for the second interview. At this time you will be given a summary of the transcribed material from the initial interview. You will be given the opportunity to comment on any aspects of the research and change the content of the transcribed material.

Without identifying you personally, direct quotations from the interviews may be used in the reporting of the results of this research. Any other personally identifying information such as your name or other persons that you have mentioned during the course of these interviews, will not be included in the final report.

The audio-tapes and transcribed material will not be available to any persons other than the researcher and other members of the research team. At the end of the study, the researcher will erase the audio-tapes and shred the transcribed material.

Your participation in this Study is voluntary and you may be terminated at any time. Should you have any questions about the procedures, you may ask them at any time. There are no known risks to the participating in this Study.

I HAVE READ AND UNDERSTOOD THE ABOVE AND CONSENT TO BE A PARTICIPANT IN THIS STUDY.

I ACKNOWLEDGE RECEIPT OF A COPY OF THE CONSENT FORM.

Name of participant:

Signature:

APPENDIX C

Question to Participants

Orienting Statement:

We know very little about the bereaved's experience of coming to terms with loss of a loved one through counselling. The existing literature in this area has focused on the specific behavioral changes associated with the grieving process. Very little attention has been placed on investigating the client's experience. Could you tell in as much detail as possible, how you attempted to make sense of your loss, through your experience of counselling? It may be helpful to think of your experience and describe it to me as a story, with a beginning, middle and end.

Initial Interview - Part two

The following questions will be explored by the researcher, if the participants have not discussed them:

1. Were you in therapy to work through your loss?
2. How long were you in therapy?
3. When did you terminate therapy?
4. Who decided to terminate therapy?
5. What specific aspects or events in this process affected you most?
6. What occurrences in therapy helped you most?
7. What occurrences could have been helpful?
8. Can you remember comfortably the pleasures and disappointments of your lost relationship?
9. How would you describe yourself at the beginning of therapy and how did you change over time?